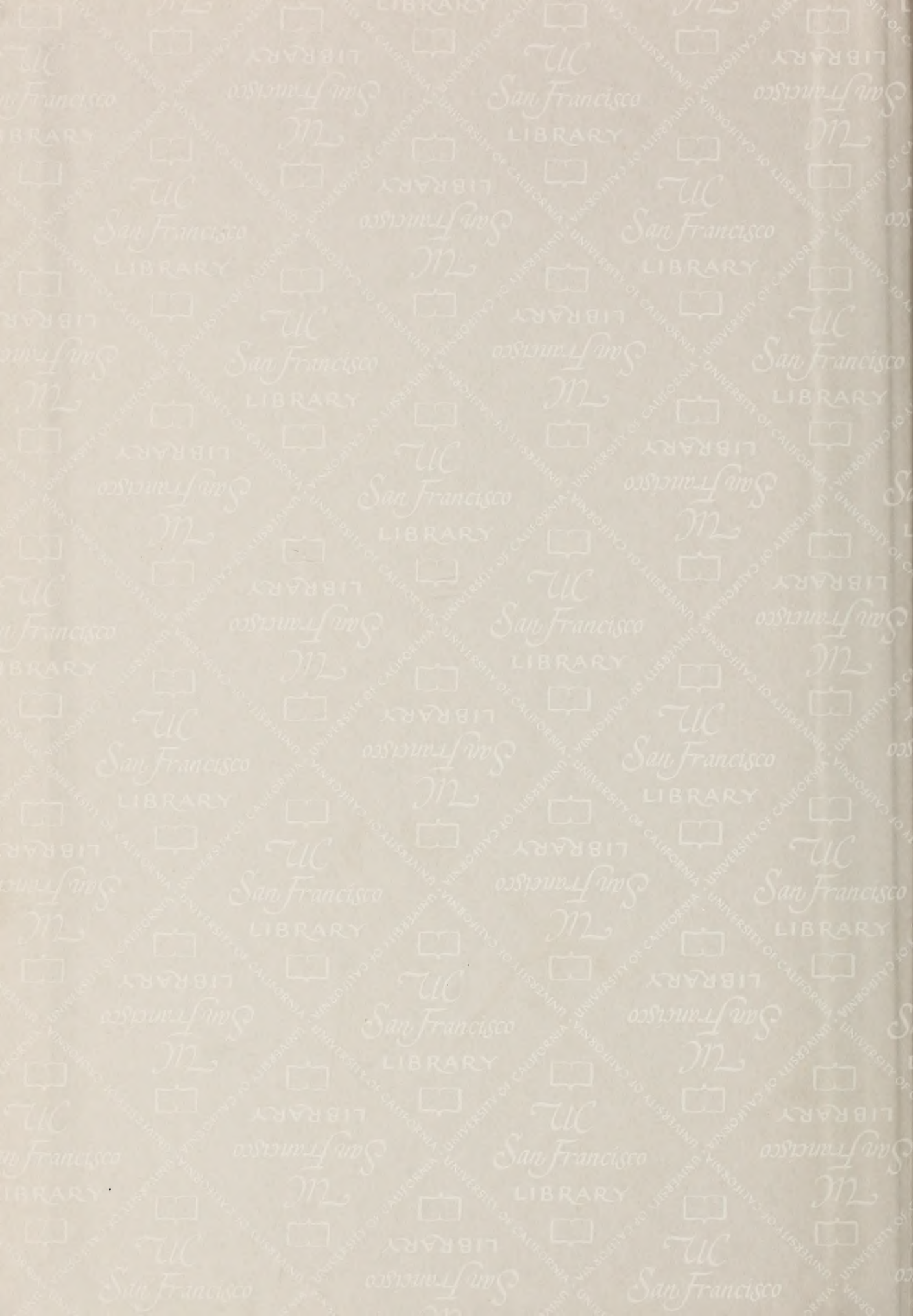



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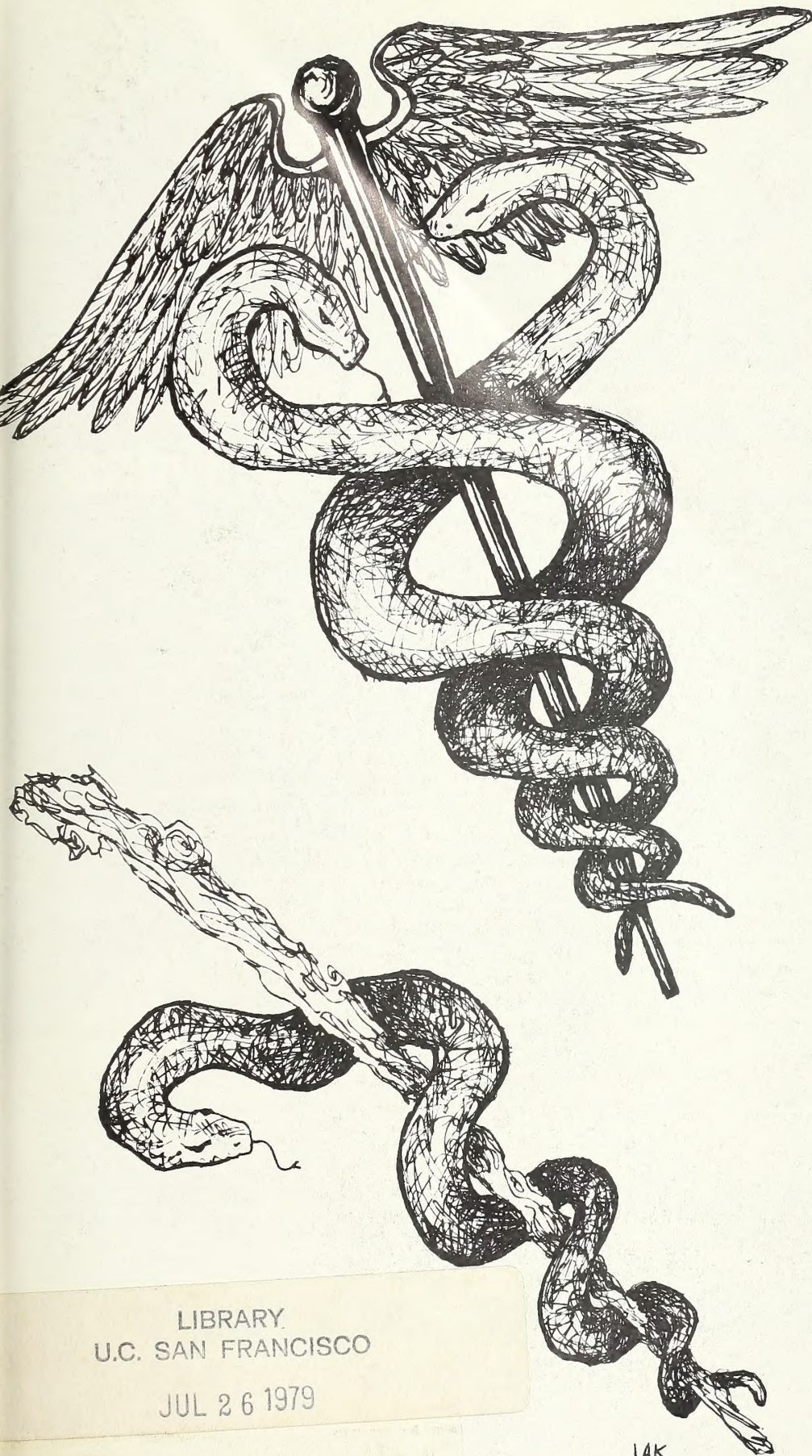
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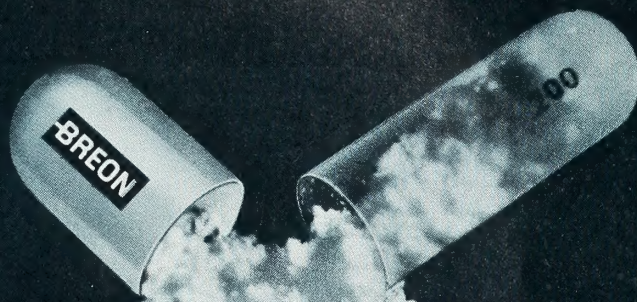
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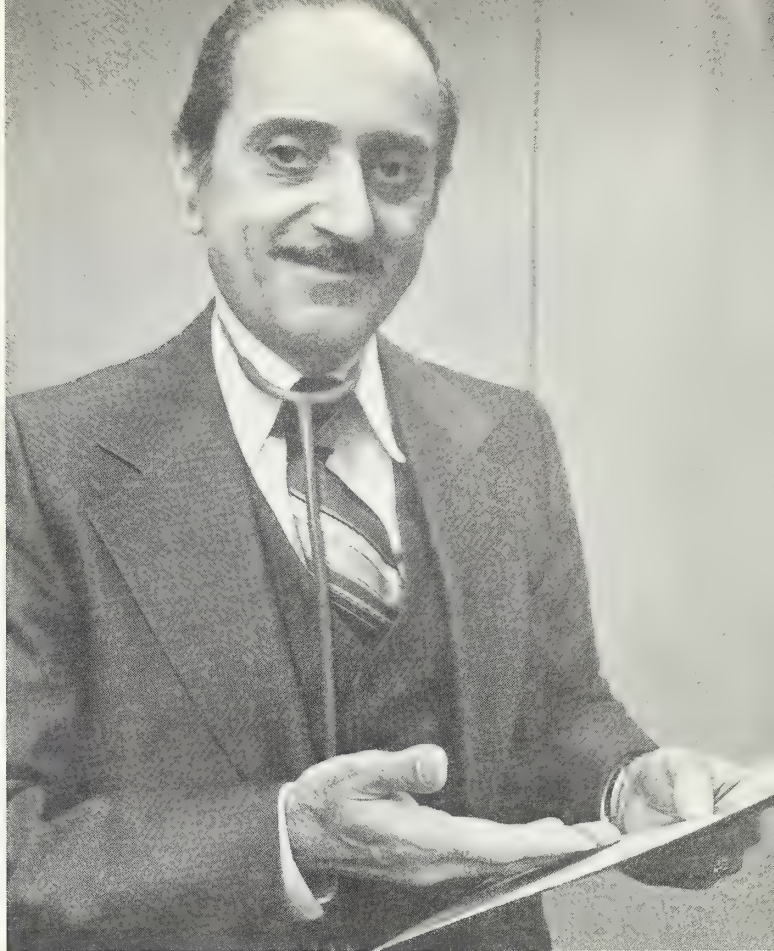
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The Caduceus

The term "caduceus" has its origin in the Greek word "kerikion," meaning a herald's wand. Originally, this was an olive branch carrying fillets of wool later displaced by white ribbons, and later replaced by a staff carrying symbols of snakes. Excavations throughout the known world, extending from Greece to China, have produced extraordinary works of art such as knife handles, libation cups, heads of animals, and heads of deities decorated by snakes. The oldest type of caduceus was found on Babylonian cylinder seals showing the head of both a male and female serpent attached to a single body which was thought to signify a sexual symbol. This caduceus was on the staff of Mother Goddess Istar of the Babylonian civilization.

About 5000 B.C., in the Mycenaean civilization of Greece, the Mother Goddess of Fertility appeared holding snakes in her hands. In Egypt, Crete, and Palestine the snakes again were prominent on the staffs of deities and of healing men.

Serpents played notable roles in religion, philosophy, politics, and the art of healing in ancient cultures. From Greece, where most of this information was gathered, we learn how the snake became associated with the god Asklepios. Asklepios was a human practicing medicine in Thessaly where he was born. As his fame and the centers of his practice spread throughout the known world, a special folklore grew about him which eventually was handed down in Greek mythology. Homer mentioned an incident in which a young hero died while Asklepios was tending him. On the scene came a snake which Asklepios killed with his staff. This snake was followed by another one which brought an herb, placed it in the mouth of his dead friend and brought it back to life. Asklepios, recognizing the value of the herb, used it on his dead patient and thereby revived him. As his medical centers became established as centers of religion and medicine, Asklepios eventually was deified. The three best-known centers were in Epidaurus, the Island of Kos, and in Delphi.

Excavations in Epidaurus have revealed a temple with a snake pit, forty-four stone tablets with engraved diagnoses for treatment of varying ailments including skin diseases, obstetrics, and abdominal problems. Therapy varied from collyrium for the eyes to medical potions, and surgery of the abdomen. There was a great deal of massaging and manipulating of the back and spine as they were thought to be the centers of general body ailments. The snakes selected were non-poisonous ones which the priests of the temple carried with them into their treatment rooms for use in the licking of wounds. This licking was quite common, and was done by other animals such as dogs and cats, and sometimes by the priests themselves, according to those who did not believe the snake theory. A great deal of the therapy was given in

darkness with mysterious chanting to the gods, including suggestion and probably hypnotism. Thus, we are told in Greek history and in the findings of Epidaurus that the thousands of patients who were brought to this and other similar temples would be treated through religion, medical management, and gymnastics. The centers commonly contained a stadium in which young athletes exercised and took hot and cold natural baths. Amphitheaters brought large numbers of people together to witness these rites. Much of this seems to be the predecessor of some of the existing religious shrines and cults whose appeal to the public still goes on with mysticism and mass hypnotism.

The *Staff of Asklepios*, as shown on statuary in his honor, appears as a man-sized staff with a large single snake entwining itself from the base upward. Such statues now are found in the Louvre Museum in Paris, in Copenhagen, Florence, Dresden, and Naples. These are great copies of originals done by Phydias, the creator of the Discobolus, or Discus Thrower, as well as by Myron. A similar staff with snake is referred to in the *Bible* as one being used by Moses. It is said that such a golden staff with one snake was looked to by the Jews when bitten by snakes during their stay in the desert.

Hermes' Staff—another famous staff with two snakes appeared in mythology in the hands of Hermes, or as he was known to the Romans, Mercury. This young god was admired by Apollo who gave him the staff to carry as a symbol of his office in executing his missions with speed and authority. The beauty of the statue of Hermes, as shown in the museum on the Acropolis in Athens, is reproduced by the delicate insignia of the Western Union Company. The staff is the same one that the U.S. Army Medical Corps displays on its insignia. The snakes, looking at each other, entwine from the base to the top where a pair of wings is attached, prompting their carrier to go in speed, bring peace among the powers of darkness, and overcome disease. Another school of philosophy tells us that the snakes represented the powers of good and evil, known as Agathodaemon and Kakodaemon, which, when held by the strong master, would be kept in good balance.

In 1818, the U.S. Surgeon General's office combined the Asklepiian staff on a shield with the Stars and Stripes. In 1912, the American Medical Association made the Asklepiian symbol its official logo as has, more recently, the U.S. Department of Health, Education, and Welfare.

Today, as we are faced with challenges both from within and without the medical profession, let our caduceus represent the balance between Agathodaemon and Kakodaemon.

Aris M. Sophocles, M.D.

Canadian Health Care: The Flip Side

An article entitled "The Health Care System in Canada: It Works" by John E. Brockelbank, speaker of the Legislative Assembly in Saskatchewan, Canada, was published in this *Journal* in April, 1979 (76:279-282). As the title suggests, the author was enthusiastic but he brooded about the escalating health care costs, which, he said, "we can no longer accept." With political double-speak, the solution was: "Since reducing access to health care is not an acceptable option we must assume greater responsibility for our health status and a more responsible attitude toward the use of health care services."

The flip side of this coin was discussed in a recent article by Ramsay W. Gunton, M.D., Professor of Medicine at the University of Western Ontario.* At our request, Professor Gunton commented on the Brockelbank article in a letter published in this issue (page 548).

Another opinion of national health insurance, Canadian style, recently was written by Orrin G. Hatch, United States Senator from Utah:

"Great Britain's experience with National Health Insurance really leaves something to be desired. So let's take a look at the socialized medicine report from our good neighbors to the north.

"Canada's federally operated health service began 20 years ago and its experience hasn't been much better than Britain's. It all began with the government covering hospital costs. The doctor's bills were added about 10 years later. Between 1960 and 1978 hospital costs increased 424 percent and the cost of a doctor's care increased by 71 percent, despite a promise from the Canadian government that hospital costs and physician care would naturally go down with National Health Care. The law makers in the Parliament also promised a halt to over-utilization of medical services but Canadians now spend 1.8 days per year in a hospital compared to 1.2 days for Americans.

"One of the most common promises heard in the debate on National Health Insurance in the U.S. is that maldistribution of doctors will be corrected and citizens will soon find adequate health services within easy access of their homes when the government takes control. The Canadian experience would dictate something different. Rural doctors are still hard to find and inner cities remain physicianless. There is an over-abundance of high-priced specialists and a shortage of general practitioners. Doc migration to the U.S. is an unpublicized national problem for the Canadians.

"A recent survey shows that Canadians now pay more for 'free' government-sponsored health care than they would pay under a free market system. The analysis is based, not only on the taxes they pay for health care, but on the dollars lost in excessive waiting to receive that care.

"Another study by UCLA shows that low income groups in Canada get somewhat better health care than their counterparts in the U.S. This increased service, however, is offset, according to UCLA, by cutbacks in funds for aid to the blind and disabled, workman's compensation, family

allowances, and other welfare programs.

"The money for the Canadian National Health Insurance program comes directly from general revenues in the treasury based on a two percent income tax surcharge which was added in 1968 with the doctor bills. In spite of this, one out of every two Canadians still buys private health insurance to supplement the government's program, according to the *Chicago Tribune*.

"Consistent analysis shows that in spite of its few failings the free enterprise delivery of health care is superior, both in low cost and better, more timely service. National Health Insurance is not free. It will cost every Utahn dearly both in service and in dollars and cents. History proves it." (Orrin G. Hatch, United States Senator--Utah, October 1978)

In the careful econometric study of the Canadian National Health Insurance program to which Hatch refers, Lindsay, Honda, and Zycher stated:**

"Our results here indicate cause for genuine alarm.

"Our conclusions are that in the short run, there may be some redistribution of medical care away from high income groups to low income groups, but that this does not lower the cost to any group. Because the supply of medical care is not increased materially when the government offers it free, this care must be rationed by other means. The net effect is, therefore, that such a program greatly increases the cost for most. The average citizen must, with this sort of "give-away" program, pay for his medical care twice: first by paying taxes to finance it and secondly by waiting in line or by putting up with lower quality medical care.

"In the long run, on the other hand, the reimbursement scheme adopted by Canadian NHI may decrease access to medical care to those very groups who had less access prior to the program's introduction. We developed an economic model of physician location which suggested that, in the long run, physicians under the present reimbursement system have a greater incentive to locate in environmentally and socially attractive areas. They will locate in fewer numbers in rural and remote locations already suffering a relative shortage of physicians.

"Finally, our study has sought to find out who actually pays for National Health Insurance. Our results here indicate cause for genuine alarm. We find that both the hospital and medical care parts of the program have been financed by displacement in the budgets of other social welfare spending categories. While it has been shown that, in the short run, low income groups seem to get somewhat more care than they would have been able to obtain before NHI, they are not the only groups consuming care under the program. Sixty cents of every dollar spent on these combined programs is taken from cutbacks in funds for aid to the blind and disabled, workman's compensation, and family allowances. Such an arrangement seems inconsistent with at least some of the broader aims of all these programs."

What are the lessons for the United States from the Canadian NHI scheme? According to these critics, they include the following:

1. Canada's NHI has displaced funds from existing social welfare programs, but has actually increased government spending without lowering costs to any income group.

2. The system has failed to increase access to medical care for the poor.

* National Health Insurance—Caveat Emptor. *Forum on Medicine* (A.C.P.) April, 1979.

**Lindsay CM, Honda S, Zycher B: Canadian National Health Insurance. Lessons for the United States. Nutley, New Jersey, Roche Laboratories, 1978.

3. Under their government-financed "give-away" scheme, Canadians pay twice for their medical care—through taxes and through hours of waiting in a queue.

4. Since income levels for the Canadian physicians are relatively fixed, there has been a significant shift toward geographically and socially "attractive" areas, including the United States. According to Gunton, between 800 and 1000 Canadian physicians left Canada for the United States in 1978.

5. Canada's NHI has attempted to contain its costs by limiting the immigration of physicians, reducing residency positions, and dragging its heels on doctors' incomes, which lag behind inflation and the incomes of other professions and trades.

Gunton* believes that "first-dollar coverage for hospital and medical services" which is one of the reasons for the public addiction to health care services, is irreversible. Lindsay** feels the present private insurance industry in the United States, which tends to provide first-dollar coverage, with fairly low deductibles and inadequate coverage for

catastrophic illness, is making a mistake. He suggests that higher deductibles would permit private insurance companies to "charge lower premiums and finance extended coverage with the money saved through the increased deductibles." Such a system at once would dampen the insatiable public desire for unnecessary health services which is contributing to the bankruptcy of the present American health care system, and would provide protection against the loss of the family "nest egg," at a reduced cost to the nation.

Professor Lindsay** summarized the lessons from the Canadian experience as follows: "All you have to do is look at the experiences of the government-run postal system, or the Amtrak takeover, to realize the problems government intervention can create. I shudder to think this type of an experience (Canadian NHI) could be repeated in the American medical care industry. Our government is a notoriously bad organizer, and I think we would be making a big mistake that we ultimately would regret if we instituted a government-controlled and financed NHI system here."

A.K.

The Dumping Syndrome

As the years pass, we tend to feel that the world is growing smaller because international travel is quick and easy. Major changes in life style have become notable in the eastern world, where nations such as Japan and China seem hell-bent-for-leather to adapt western ways. The most recent west-to-east acquisition has been "the dumping syndrome."

Typically, those of us who have had occasion to work in hospital emergency rooms have, from time to time, had to deal with the situation wherein the young couple, about to go on vacation, bring granddad—a septuagenarian widower—to the accident ward with his suitcase in hand. "What is the problem?" you ask. "Dad is weak, sleepy, confused, and needs to be in the hospital," you are told. "Why?" you inquire. "He can't take care of himself—and he wets the bed."

After a careful examination, which mainly reveals general arteriosclerosis, a modicum of organic mental syndrome, and an enlarged prostate, you suggest that the elderly widower need not be in the hospital, but can be cared for at home more easily and better. You can fill in the rest of the dialogue.

It seems that the traditional filial piety of Japan is being bumped aside by our now familiar "dumping syndrome." Since 1973, when all people aged 70 and older became eligible for free medical care, more Japanese families are ridding themselves of a financial and social burden by sending aged parents to the hospital. Dr. Junichiro Sato, director of the Omura Municipal Hospital in Nagasaki prefecture tried to discharge a group of old patients from his

hospital to their homes because they did not require medical care. He was required to explain his behavior before the city assembly who were informed that "hospitals are not meant to be an old people's dump with doctors and nurses."*

There is a shortage of homes for the aged in Japan, and younger residents object to construction of such residences in their neighborhood. Applicants for beds in one of the 2,000 such institutions wait more than a year for admission, often occupying an expensive hospital bed because the family refuses to take them back. Economic reasons and inadequacy of housing seem to be major obstacles to three-generation. The shortage of beds in "old persons' homes" is also matched by the shortage of nursing homes.

Is the situation benign? Not really, because the suicide rate for the aged was 49.3 per 100,000 as compared to 18 per 100,000 for the population as a whole. Last year, 4,891 persons 65 years or older committed suicide—nearly one-fourth of the nation's total suicides.

Our late Vice President, Hubert Humphrey, criticized the United States nursing home industry for "warehousing" the elderly. It seems clear that the criticism should be directed where it belongs—at the families who refuse to care for their elderly at home rather than at the institutions in which they are "dumped." This is true in the United States, Japan, and everywhere. Neither government nor an institution can substitute for a loving, considerate, and respectful family.

A.K.

*Jameson, S: Fewer bowing to Japan tradition of filial piety. *Los Angeles Times*, June 9, 1979.

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Malignant Neoplasms in Long-Term Hemodialysis Patients*

A. OLUSEGUN FAYEMI, M.D.
MAJID ALI, M.D., Teaneck

Twelve neoplasms occurred in ten patients maintained on hemodialysis for chronic renal failure. All the tumors except one were epithelial. There was a rapid deterioration in the clinical course of these patients and the cause of death in five was attributable directly to the tumors. The discussion focuses on the factors that may contribute to this complication in patients with chronic renal failure.

An increased incidence of malignant neoplasms has been shown to occur in patients with chronic renal failure. Ten tumors were described in nine of 646 dialysis/transplant patients during the period of progressive uremia.¹ This is a significantly increased incidence over the expected number in the age-matched general population. Similarly six of 47 patients who had been maintained on long-term hemo- or peritoneal dialysis developed malignant tumors which directly were not causing their renal failure.²

While investigating various aspects of the pathological changes occurring in hemodialysis patients that were autopsied, ten patients with malignant neoplasms were encountered. The present communication concerns the clinical and pathological study of these patients.

MATERIALS AND METHODS

The autopsy files of Holy Name Hospital for the years 1969 through 1977 were examined to identify patients with chronic renal insufficiency maintained on hemodialysis. Eighty cases were found with adequate clinical and pathologic material. They were maintained on hemodialysis for periods ranging from three weeks to seven years. Clinical information was derived from both the hospital records and the clinical summary that forms a part of the postmortem record. The histologic slides were examined with the aim of obtaining the following information: the underlying chronic renal disease, the presence of malignant neoplasms, impor-

tant associated diseases, and the immediate cause of death. The following data were obtained from the hospital records and clinical summaries: the ages and sex of the patients, the duration of hemodialysis treatment before demise, and the clinical symptoms occurring immediately prior to death.

RESULTS

Hemodialysis Patients—During the period surveyed, 392 patients were admitted for and maintained on hemodialysis for chronic renal failure. Of those that died, complete postmortem examination was performed on 80 patients. There were 43 men and 37 women, ranging in age from 15 to 84 years with an average of 55.8 years. Of these, ten patients (12.5 percent) had malignant neoplasms. Clinical data regarding these patients, the etiology of their renal failure, duration of hemodialysis treatment, and the type of neoplasm they developed are shown in Table 1.

Hemodialysis Patients with Malignant Neoplasms—Their ages ranged from 26 to 78 years. Eight were men. The tumors encountered were predominantly of epithelial origin. Two

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Table 1
Malignant Neoplasms in Ten Hemodialysis Patients: Clinicopathologic Data

Patient	Age	Sex	Neoplasm	Primary renal disease	Duration on hemodialysis (months)	Immediate cause of death	Associated disease
1	26	F	Papillary carcinoma of thyroid	Chronic pyelonephritis	14	Congestive heart failure	
2	63	M	Prostatic carcinoma	Nephrosclerosis	48	Acute myocardial infarction	
3	66	M	Glioblastoma multiforme	Nephrosclerosis	5	Glioblastoma multiforme	Thyroidectomy for follicular carcinoma of thyroid
4	78	F	Hepatocellular carcinoma	Diabetic nephropathy	11	Liver cirrhosis	Irregular cirrhosis
5	55	M	Rectal carcinoma	Nephrosclerosis	16	Septicemia	Lymphocytic thyroiditis
6	71	M	Hepatocellular carcinoma	Chronic pyelonephritis	26	Liver cirrhosis	Irregular cirrhosis
7	67	M	Carcinoma of lung	Diabetic nephropathy	4	Carcinomatosis	
8	69	M	Pancreatic carcinoma Gastric ulcer carcinoma	Chronic pyelonephritis	4-1/2	Gastrointestinal bleeding	Multinodular goiter
9	70	M	Renal adenocarcinoma	Chronic pyelonephritis	2	Carcinomatosis	
10	76	M	Colonic carcinoma	Chronic pyelonephritis	2	Carcinomatosis	

patients with hepatocellular carcinoma had associated liver cirrhosis. In Case 9, primary renal carcinoma with metastases was found in one kidney. The contralateral kidney revealed typical chronic pyelonephritis. Two patients had double malignant tumors. In Case 3, they were asynchronous, thyroidectomy having been performed for follicular carcinoma of the thyroid before the diagnosis of glioblastoma multiforme. In Case 8 both tumors occurred simultaneously: pancreatic carcinoma was diagnosed antemortem and a gastric-ulcer-carcinoma was found incidentally at autopsy.

Cause of death—Five patients died as a direct result of widespread metastases or direct effects of the malignant neoplasm. Acute myocardial infarction secondary to coronary atherosclerosis and coronary thrombosis was encountered in one patient. Congestive cardiac failure was seen in another. One patient developed septicemia resulting from pyonephrosis. Two patients died of liver cirrhosis.

COMMENT

It has been reported that up to 6 percent of home-dialysis deaths and 2 percent of hospital-dialysis deaths may be due to malignant neoplasms.³ Other estimates have put the cancer death rate in chronic hemodialysis patients at about one percent.⁴ An analysis of the types of tumors reported in the English literature is shown in Table 2. Seven of 32 tumors (22 percent) recorded were renal cell carcinomas. In six of these seven patients, the etiology of the chronic renal disease was chronic glomerulonephritis (2), chronic pyelonephritis (2), nephrosclerosis (1), and polycystic kidney disease (1). The association of renal carcinoma with polycystic kidneys is known but not widely recognized.⁵ The tumor is usually unilateral although bilateral asynchronous and synchronous carcinomas have been reported. Unlike polycystic kidney disease, other primary chronic renal diseases have not been shown to be associated with high incidence of renal tumors. Recently however, Dunnill *et al.*, describing acquired cystic disease of the kidneys as a hazard of long-term intermittent

Table 2
Malignant Neoplasms Developing in Chronic Intermittent Hemodialysis Patients: An analysis of 35 tumors in 32 patients.

Neoplasms	Number of Cases	References
Renal cell carcinoma	7	6, 30, 1, 2, p*
Carcinoma of thyroid	4	30, 1, p*
Carcinoma of breast	3	1
Carcinoma of urinary bladder	2	30, 31
Carcinoma of lung	2	1, p*
Reticulum cell sarcoma	2	30, 31
Basal cell carcinoma (skin)	2	2
Hepatocellular carcinoma	2	p*
Colonic carcinoma	2	p*
Gastric carcinoma	2	2, p*
Chronic lymphocytic leukemia	1	1
Prostatic carcinoma	1	p*
Insulinoma	1	1
Glioblastoma multiforme	1	p*
Carcinoid of small intestine	1	2
Carcinoma of pancreas	1	p*
Carcinoma-in-situ of uterine cervix	1	1
Total	35	

*Present paper

hemodialysis, noted the development of renal tumors in six of 30 patients.⁶ In five of these, the tumors were multiple. The tumors arose from the lining of the cysts and microscopically were papillary, tubular, or solid. The histological appearances of the tumors gave no indication as to their probable biological behavior. One of their patients, aged 56, who had been on hemodialysis for two years, died of metastatic carcinoma from a primary renal tumor.

In Case 9, renal carcinoma was present involving the entire right kidney that weighed 1400 grams. Postmortem examina-

tion revealed metastatic carcinoma to liver, adrenals, lymph nodes, and the lungs. The contralateral kidney showed chronic pyelonephritis. The patient was on hemodialysis for only two months although renal insufficiency had been diagnosed for a longer period. It is most probable that the destruction of one kidney by the tumor contributed to the severity of his terminal renal insufficiency.

Hepatocellular carcinoma was encountered in two patients aged 71 and 78 years who had been on hemodialysis 26 and 11 months respectively before death. Both patients had irregular (postnecrotic, multilobular) cirrhosis. Hepatitis-associated antigen was present in the serum of one patient and was demonstrable in the hepatocytes (by the Shikata-orcin stain) of the other. The hepatocellular carcinoma may be considered a complication of liver cirrhosis, that in itself was preceded by viral hepatitis. A high incidence of viral hepatitis is known to occur in both the patients and the staff of hemodialysis units.⁷⁻⁹ Contamination rates (chronic carriers of Hepatitis B surface antigen and clinical hepatitis) may be as high as 55 percent in patients and 34 percent in staff of such units.¹⁰ Hepatitis is much less frequent in hemodialysis patients than in those treated in centers.¹¹ The presence of Hepatitis B surface antigen (HB_s Ag) may be transient or persistent in hemodialysis patients. In a recent study, antigenemia lasting longer than 18 months was found in 40 percent of dialysis patients. The persistence of hepatitis B antigenemia in hemodialysis patients is similar to that described in patients with Down's syndrome,¹² lepromatous leprosy,¹³ lymphatic leukemia and those treated with immunosuppressive drugs.¹⁴

A difference exists in the clinical features of hepatitis in hemodialysis patients and the healthy population. In the former there is a high rate of anicteric hepatitis. In a survey of 65 hemodialysis centers, hepatitis was anicteric in 68 percent of HD patients in contrast to 15 percent in staff members.⁷ The literature contains scanty information regarding the subsequent course of hepatitis in HD patients. However, both chronic aggressive and chronic persistent hepatitis have been described. Cirrhosis evolved in some European patients.¹⁵ To our knowledge hepatocellular carcinoma complicating liver cirrhosis in hemodialysis patients has not been reported previously.

There is an increased incidence of malignant tumors in patients treated with immunosuppressive therapy following organ transplantation.¹⁶⁻¹⁹ The pathogenesis of this increase has been attributed to a variety of mechanisms. The drug therapy may cause chromosome breakage,²⁰ lead to impairment or loss of immune surveillance for neoplastic mutant cells,²¹ or permit proliferation of oncogenic viruses.²² Similarly, an increased incidence of malignant neoplasms occurs in uremic patients.^{1,2} This has been related to immunosuppression that is associated constantly with chronic renal failure.²³ Discordant data are published concerning humoral antibodies and complement in the uremic state.²³⁻²⁵ That cellular immunity in chronic renal failure is depressed is supported by the results of numerous studies. Decreased skin reactivity to tuberculin, histoplasmosis, mumps, and candida antigens was observed in 45 patients with chronic renal failure.²⁵ There is prolongation of survival time of skin grafts in rats made uremic by partial nephrectomy.²⁶ The survival time of the grafts was correlated closely with the level of blood urea nitrogen. Similar prolonged survival of skin homografts has been demonstrated in uremic patients.²³ Other investigators have demonstrated poor inflammatory response to diphtheria toxoid²⁷ and an impaired ability for

polymorphonuclear leucocytes to engulf *Bacillus subtilis* in patients with chronic renal failure.²⁸ Other evidence supporting altered cellular immunity in chronic renal failure includes lymphocytopenia, thymic atrophy, failure of lymphocytes from uremic patients to elicit graft versus host response when injected intradermally in lymphocyte transfer tests, and decreased viability of uremic lymphocytes.²⁹

By contrast to malignant tumors arising in patients following renal transplantation and immunosuppression therapy where the preponderance of the tumors are lymphoreticular (particularly histiocytic lymphoma), or mesenchymal, the malignant tumors in chronic uremia are predominantly epithelial and distinctly nonlymphoreticular. An explanation for this difference is lacking at the present time; it has been suggested that it may be due to the presence of the graft in the transplant patients or may be due to different patterns of immunosuppression in these two populations.¹

The outlook of patients on hemodialysis with malignant tumors is obviously more bleak than those without tumors. This factor assumes greater importance the longer the patient survives after the development of the uremia. The frequency with which malignant tumors contribute to or constitute the major cause of death in these patients is not known. In the present study, the immediate cause of death in five patients was a direct result of the neoplasia: disseminated metastatic carcinoma in three, cerebral neoplasm with its associated problems in one, and gastrointestinal bleeding due to a gastric ulcer-carcinoma in another. Clinically, the patients develop progressively worsening conditions characterized by loss of weight, fever, and symptoms relating to the location of their neoplasms. In two patients the diagnosis was made only postmortem. We therefore urge that intensive investigation be instituted in patients on hemodialysis who show unusually rapid deterioration with the aim of discovering and probably treating occult malignant neoplasms.

SUMMARY

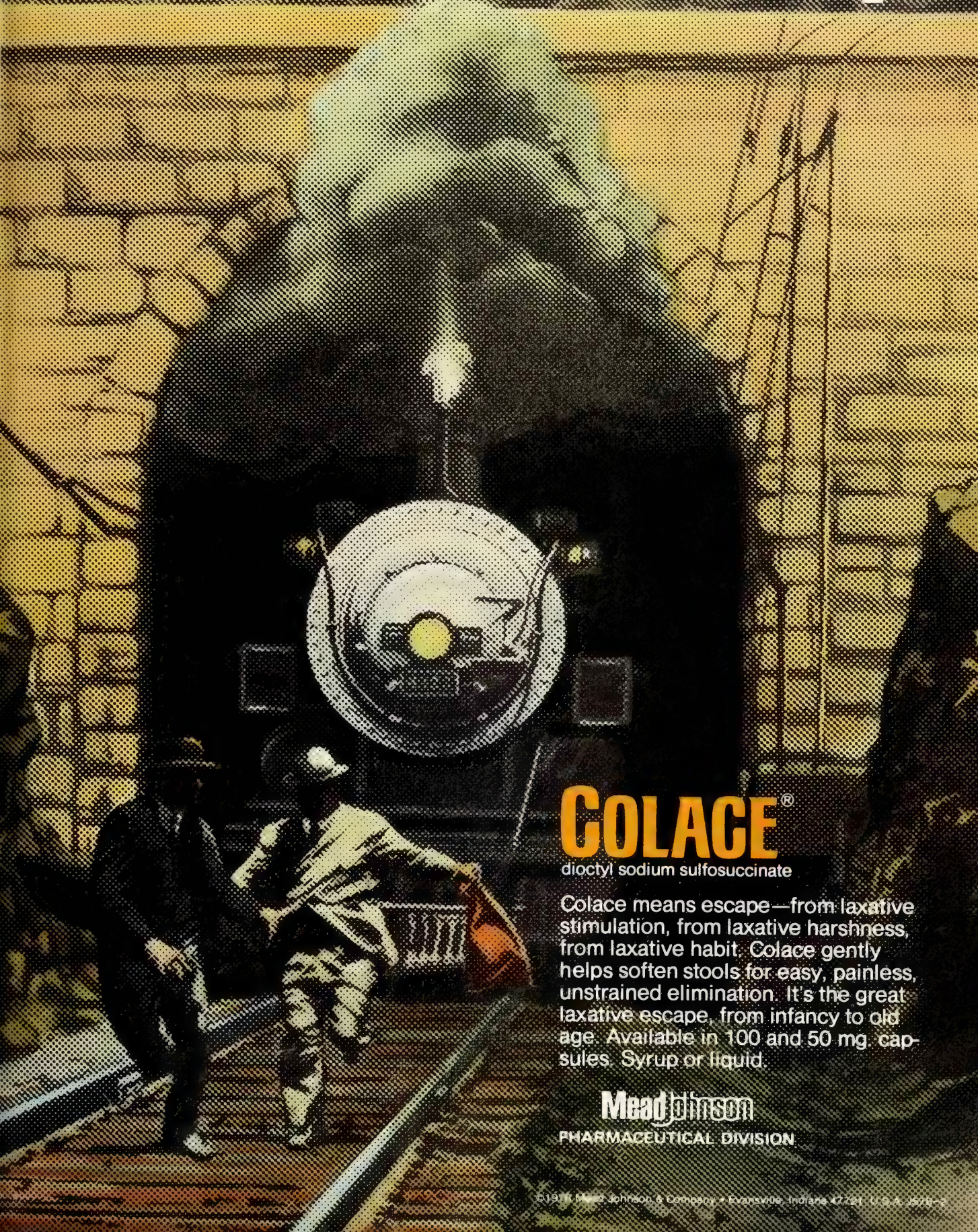
An increased incidence of malignant neoplasms occurs in patients with chronic renal insufficiency maintained on long-term intermittent hemodialysis. Ten such patients in whom twelve malignancies developed were encountered in a hemodialysis unit over the period 1969 through 1977. The tumors were predominantly epithelial—carcinoma of the thyroid (2), liver (2), colon (2), lung (1), stomach (1), kidney (1), prostate (1), pancreas (1). One patient developed glioblastoma multiforme. In five patients death was attributable directly to the neoplasms. Numerous abnormalities of cellular and humoral immunity occur in uremic (and hemodialysis) patients and may contribute to this problem.

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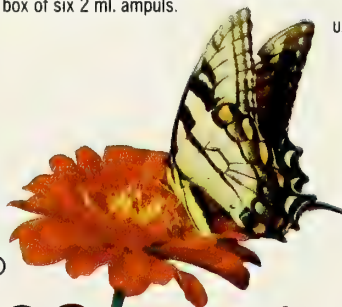
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Tonsils and Adenoids: Tradition or Science

RICHARD H. RAPKIN, M.D., Newark*

Tonsillectomy and adenoidectomy are procedures with a strong tradition. However, the value of these operations has not been subjected to careful scientific scrutiny. Because these organs function in body defenses and because their removal has morbidity, mortality, and incurs substantial cost, physicians need to be circumspect in their recommendations for surgery.

We shall have to learn to refrain from doing things merely because we know how to do them." (Fox, 1965)

"A careful physician . . . , before he attempts to administer a remedy to his patient, must investigate not only the malady of the man he wishes to cure, but also his habits when in health, and his physical constitution." (Cicero, 45 B.C.)

In New York in 1934, 61 percent of 1000 school children were found to have had tonsillectomy.

"The remaining 39 percent were subjected to examination by a group of physicians, who selected 45 percent of these for tonsillectomy and rejected the rest. The rejected children were reexamined by another group of physicians, who recommended tonsillectomy for 46 percent of those remaining after the first examination. When the rejected children were examined a third time, a similar percentage was selected for tonsillectomy so that after three examinations only 65 children remained who had not been recommended for tonsillectomy. These subjects were not examined further because the supply of examining physicians ran out." (Bakwin, 1945 quoted in Illich, 1976)

This review is an attempt to place the tonsils and adenoids in the general perspective of normal organs performing normal functions. My thesis will be that it is unconscionable to remove tonsils and adenoids without adequate data to support such therapies.

ANATOMY AND PATHOLOGY

The palatine tonsils develop during the third fetal month in the region of the second pharyngeal pouches. Ingrowths of ectoderm burrow into the mesenchyme establishing crypts. During the fourth fetal month there is infiltration of lymphocytes. The adenoids (also called nasopharyngeal tonsils) develop in similar fashion from endoderm, mesenchyme and lymphocytic infiltration during the sixth fetal month.

The tonsils essentially are masses of lymphoid tissue located in the tonsillar sinus. The medial surface is free and the lateral surface extends superiorly into the soft palate and inferiorly into the dorsum of the tongue. The superior pole has a deep cleft, and the free surface has 12 to 15 orifices leading to deep recesses (crypts) penetrating nearly the whole thickness of the tonsil. These crypts are lined by stratified squamous and columnar epithelium which is continuous with the pharyngeal mucous membrane. They often contain plugs of dead lymphocytes, bacteria, food, and desquamated epithelium. The substance of the tonsils contains lymphoid follicles with germinal centers. Efferent lymphatics drain the

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tonsils to the cervical lymph chain. There are no afferent lymphatics or sinuses.

The adenoids are folded masses of lymphoid tissue surrounding and anterior to the pharyngeal opening of the eustachian tube. There are mucous glands in their substance as well as fissures lined by ciliated columnar epithelium. Both tonsils and adenoids are a part of a circular band of lymphoid tissue surrounding the digestive and respiratory tracts. The lingual tonsils are anterior and inferior; the palatine tonsils are lateral and the adenoids are superior and posterior. This grouping is called Waldeyer's ring.

During infancy and childhood the lymphoid tissue of the body, including the tonsils and adenoids, grows rapidly, reaching a size equal to adult size by about age six and then increasing to twice that size by age ten before regressing during puberty. Since the size of the nasopharynx is approximately 50 percent of adult size at age six to ten, the relative size of tonsils and adenoids to the nasopharynx may be as follows: in the six year old, 2:1, and in the 10 year old, 4:1, and in the adult, 1:1.

During acute inflammation of the tonsils, the crypts become distended with debris, polymorphonuclear leukocytes, mucous, bacteria, and fibrin. There is acute congestion and swelling of the whole tonsil and proliferation of lymphoid tissue. In the condition called "chronic tonsillitis," there is stated to be an increase in lymphoid tissue and connective tissue stroma. However, since normal tonsils rarely are examined pathologically, the distinction between "chronic tonsillitis" and normal tonsils never has been made.

PHYSIOLOGY

Tonsils and adenoids are immunocompetent lymphoid structures which regularly are exposed to the external environment and are a primary site of initial contact with inhaled and ingested antigens. The tonsils are probably more immunologically reactive than other lymphoid tissue during early life. They contain B and T lymphocytes and produce immunoglobulins including secretory IgA. Local cell mediated immunity occurs after natural infection or intranasal immunization (e.g., rubella RA 27/3 vaccine) which does not seem to occur after parenteral immunization. Tonsils may function as a first line of defense. Much less is known about adenoids.

DISEASE MECHANISMS

There are four ways in which tonsils and adenoids can be related to disease states:

1. The tonsils may participate in the general inflammation of the pharynx in viral and bacterial pharyngitis. Under usual circumstances, the tonsils demonstrate their response to pharyngitis more vigorously than other pharyngeal structures. The term "tonsillitis" often is used to describe this condition.
2. The tonsils and adenoids may, under certain circumstances, be the specific site of disease. Examples are the breakdown of tonsillar or peritonsillar tissue leading to abscess, or the development of a neoplasm from the tissues of the tonsil.
3. Normal or physiologically hypertrophied tonsils and adenoids may interfere with the function of adjacent tissues. Tonsils may obstruct swallowing or breathing (e.g., in infectious mononucleosis, diphtheria); adenoids may obstruct eustachian tubes or sinus ostia; and both may affect breathing (e.g., snoring, hypoventilation syndrome).

4. The tonsils or adenoids may lose structural or functional integrity and lead to recurrent or chronic disease. Such conditions as recurrent pharyngitis, chronic nasopharyngitis, and recurrent cervical adenitis may be examples.

TREATMENT AND CONTROVERSY

When tonsils participate in pharyngitis or nasopharyngitis (mechanism 1), the disease is the result of acquisition, colonization, and/or infection by exogenous pathogens. Avoidance of these pathogens is best, if possible. When acquired, treatment aims at their eradication. There is little or no controversy regarding this mechanism and its therapy. When tonsils are the specific site of disease (mechanism 2), the current approach is surgical, by removing the offending tissue or by draining an abscess. There is hardly any doubt about efficacy here. When tonsillar structure affects respiratory or gastrointestinal function (mechanism 3), the therapeutic approach might be surgical, or medical if shrinkage may be possible (e.g., corticosteroids for infectious mononucleosis). If the tonsils really are the source of repeated or chronic problems (mechanism 4) they should be removed or their integrity and function restored.

TONSILLECTOMY AND ADENOIDECTOMY (T AND A)

There are as many indications stated for T and A as for any surgical procedure. Some of these have been discarded as medicine has progressed. McCurdy recently stated the indications as:

1. Tonsillectomy

- a. absolute indications
 1. airway obstruction
 2. malignancy
 3. peritonsillar abscess
- b. relative indications
 1. recurrent exudative tonsillitis
 2. speech pathology
- c. questionable indications
 1. recurrent sore throat
 2. cervical adenitis
 3. debris in crypts
 4. dysphagia

2. Adenoidectomy

- a. absolute indications
 1. airway obstruction
 2. recurrent middle ear disease secondary to eustachian dysfunction
 3. complicated sinusitis
- b. relative indications
 1. speech pathology
 2. orofacial anomalies
- c. questionable indications
 1. recurrent upper respiratory infections
 2. snoring

This list represents a reasonable consensus of current thinking about T and A but additional factors must be considered. The cost of tonsillectomy and adenoidectomy is immense. In some areas the rate of tonsillectomy may be more than 50 percent of the total population. Mortality and morbidity have been noted at 100 to 300 deaths per year, with a complication rate of 16/1000 cases/year. Several studies have indicated that removal of tonsils may have other consequences: it makes the clinical diagnosis of streptococcal pharyngitis more difficult, it reduces the secretory IgA response to live polio vaccine; it reduces local cell mediated immunity; and, it may increase the liability of developing

Hodgkin's disease.

The evidence of value of tonsillectomy and/or adenoidectomy must be weighed against this background of suggested indications and problems. Unfortunately, there is little or none for *any* of the proposed indications. Paradise has stated that there are only five controlled studies comparing operated and non-operated groups, and each of these studies has serious methodologic flaws. The flaws include non-random selection for surgery, failure to separate indications for tonsillectomy and/or adenoidectomy, failure to control for severity, failure to define indications for surgery, exclusion of severe cases, limited sophistication re diagnosis of middle ear disease, careless follow-up, and the failure to include a well control group. There are many, many anecdotal studies which either decry or support tonsillectomy and/or adenoidectomy. In contrast a recent, well-done, controlled study demonstrates that histories of recurrent throat infection, because they do not reliably forecast subsequent experience, should not be used as an indication for tonsillectomy.†

The need for controls may be dismissed easily but the pitfall of failing to be aware of the natural course of events can be very misleading. McCorkle and colleagues, more than 20 years ago, followed 230 children for several years. They noted that the incidence of common respiratory disease decreased with increasing age, and tonsillectomy did not affect this decreasing incidence. The conclusion could have been drawn, had there been no control group, that tonsillectomy decreased the frequency of respiratory illness. In fact, the frequency of respiratory illness decreased spontaneously.

It seems obvious that we do not know what therapies if any are appropriate for most of the stated indications. There are two, however, that do appear unequivocal. One is tonsillar or adenoidal malignancy; the other is the airway obstruction—hypoventilation syndrome. Both of these indications have not been subjected to randomized, therapeutic trials but both are life threatening and do have their natural history altered by surgery.

HYPOVENTILATION SYNDROME

This relatively rare syndrome was described as early as 1956. The syndrome includes reversible cor pulmonale secondary to obstruction of the upper airway by adenoids and tonsils. The patients present with any combination of the following: noisy breathing especially during sleep, dyspnea, somnolence, cyanosis, and signs of congestive heart failure. There is evidence of right ventricular hypertrophy and “p pulmonale” on the electrocardiogram and hypercarbia and hypoxia while sleeping. Chest radiographs show cardiomegaly, dilatation of the pulmonary artery, and sometimes evidence of pulmonary edema. Elevated hematocrits have been noted. The pathogenesis is believed to be functional and/or structural upper airway obstruction, especially during sleep, leading to alveolar hypoventilation and hypoxia. This, in turn, causes pulmonary vasoconstriction, pulmonary hypertension, cor pulmonale and, eventually, right ventricular failure. Treatment by relief of obstruction through removal of adenoids, with or without tonsils, leads to reversal of all signs and symptoms in several weeks to months.

DISCUSSION

What can be done for patients with recurrent “tonsillitis,” otitis, sinusitis, cervical adenitis, and so on, in which there is no hard data for the use of T & A? Identification of medically treatable etiologies is the first step. Next is to begin education regarding the normal frequency of illness in childhood. The term “tonsillitis” should be removed from our vocabulary (“pharyngitis” is preferred; tonsillitis is pharyngitis in someone with tonsils). There should be an explanation about the anatomy, physiology, and importance of tonsils as well as discussion of their barrier function and peculiar (often ominous) appearance. We can be continuously supportive and confident that unless and until data are forthcoming, harm is less likely to occur to our patient if we are conservative rather than aggressive.

Finally, there must be careful review of what we do. The occasional patient who has significant problems that appear to warrant surgical intervention must be assessed carefully and findings and reasons for surgery documented on charts. Short-stay hospital forms, cursory notes, and limited data breed a cavalier attitude toward these procedures. Feedback and review, which includes careful charting, auditing, second opinions, and so on, influence the frequency of surgery and the clarity of our thinking.

The ultimate aim is to care for our patients optimally. Often ignorance interferes. While we are seeking the truth, we scrupulously must avoid careless assumptions. Tonsillectomy and adenoidectomy are experimental procedures until of proved value. Their use should be under protocol, with informed consent. Until data are generated with reasonably clear answers we must resist the temptation to witchcraft.

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†See Reference #10—Paradise; Bluestone; Bachman; et al: History of recurrent sore throat as an indication for tonsillectomy. *N Engl J Med* 298:409, 1978.

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally “expensive” and generic versions are relatively “cheap.” To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

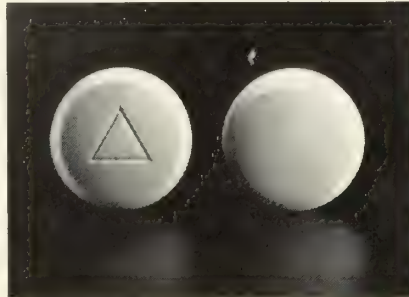
MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only “expensive” brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



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Mental Illness in Women

EDITH T. SHAPIRO, M.D., Englewood*

Current models of psychopathology and treatment of mental illness in women are unreliable according to some authors since some models fail to emphasize the predominant role of culture. According to this view, women are mentally ill mostly because they are slaves in a male sexist society. The traditional medical, psychological, behavioral, and sociocultural models are applied to descriptions of women patients to illustrate both the usefulness of a flexible approach which employs several models, and the pitfalls inherent in the rigid application of any single model.

Lazare uses a woman patient in his recent illustration of the four conceptual models in psychiatry; but there are some who maintain that the tenets of conventional psychiatry were developed in a sexist male society and hence cannot be applied to women.¹ They call for a new psychology of women developed by women therapists for women patients.^{2,3}

Do traditional medical, psychologic, sociocultural, and behavioral models apply to the diagnosis and treatment of mental illness in women? Clinical experience as well as the psychiatric literature suggest that the old models fit women as well as men and that no single model offers all the answers.

According to the medical model, exogenous and endogenous physical factors cause diseases, which manifest themselves in mental symptoms and respond to medical treatment. The psychological position is that inborn differences in the anatomy and in the psychological makeup of men and women affect early childhood experiences and lead to different manifestations of mental illness in men and women. Psychotherapy is the appropriate treatment. Mental illness is revolt against culturally determined sex-stereotyped roles or tasks according to the sociocultural model; social change and rejection of stereotypes will bring about cure. The behaviorists argue that mental illness is due to learning and subsequent reinforcement of faulty behaviors, which can be changed through behavior modification.

In a psychiatrist's office it is quite common to encounter patients who at first glance fit one of the conceptual models, and a therapist determined to demonstrate the prevalence of patients of a particular sort can do so without straining credulity. But, reappraisal frequently reveals that the patient fits into several of the conceptual models.

MEDICAL MODEL

Case One—An adolescent who suffered from severe dysmenorrhea was concerned that she might be neurotic because a teacher said that liberated women did not suffer pain while menstruating.

Case Two—An intelligent 30-year-old primagravida prepared for childbirth through reading and natural childbirth classes. Postpartum, she reported indignantly that nowhere in the process of preparation was there mention of pain, the one outstanding aspect of childbirth. Surprised and panicked by its intensity she questioned those attending her, who told her that the pain was in her head, and that she was neurotic. In addition to the pain, she felt shame at her failure as a woman.

Such patients, say Lennane and Lennane, are being treated for psychiatric symptoms, whereas these symptoms are in fact biologically determined.⁵ They report that dysmenorrhea occurs in 50 percent of women, is related to

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ovulation, and ceases when the woman reaches the mid-twenties, has a child, or uses oral contraceptives; they state that popularizers of the notion that natural childbirth occurs without pain may be misinterpreting their findings since several studies indicate that over 80 percent of women suffer pain during labor.⁵ The misinterpretation may be due to failure to differentiate the absence of complaints about pain, which is psychologically and culturally determined, from the absence of pain.

Nausea of pregnancy and behavioral disorders of infants also have been attributed incorrectly to neurotic conflicts in women.

Lennane and Lennane suggest that these biologically determined disorders are attributed by some authors to neurotic conflicts in women because of hostility to women which is endemic in our culture, and that this labeling is pejorative.⁵ Politics always makes strange bedfellows. These alleged women-haters find allies among certain feminist groups which deny or minimize suffering, concerned that admitting disability related to biological differences will lead to discrimination in social and political spheres.

The affective disorders may offer the most intriguing evidence that women differ from men in biological vulnerability. For example, epidemiological studies indicate that in contrast to schizophrenia where there is no disparity between the sexes in hospital admission rates, 1.5 women/1.0 men are hospitalized for affective disorders. The ratio increases to 1.64 women/1.00 men during women's reproductive years, with peaks around the periods of greatest endocrine upheavals.⁴ The sex difference in hospital admission rates for depression is explained by some feminists as another instance of the persecution of women by men.

Such attitudes may prejudice the care offered to the afflicted women, with the result that appropriate treatment which includes hormones, analgesics, and tranquilizers may be withheld.

PSYCHOLOGIC MODEL

The discussion of the psychological model is based mainly on the work of Freud⁶ and Horney,⁷ but I will not be able to do justice to either or to the many others who made invaluable contributions to psychological theories of psychopathology in women. I am being necessarily selective, with bias in the case of Freud, toward those ideas which have come under greatest attack and which Freud himself revised periodically.⁶ However, it is noteworthy that these ideas did mold the thinking about psychopathology in women for several generations and still are influential.

Freud affirmed that an innate psychological entity, the libido, i.e., the sexual instinct, was the same in men and women and that its vicissitudes in infancy and childhood determined both normal personality and psychopathology. Because women lack a penis the libido does not fare as well with women as it does with men. While Freud stressed anatomy, he also indicated cryptically that what constitutes masculinity or femininity is beyond the power of anatomy.⁶

Patients frequently present material which can be interpreted in accordance with Freud's views:

Case Three—A successful young career woman suffered from depressions, apparently precipitated by setbacks, or paradoxically, by good luck. Both of her parents had been hospitalized for depressive illness. The patient was competitive; ready to kill if men were more successful than she. Through graduate school, her dress evoked comments that she looked like a little boy. Shortly before she was to marry,

the patient reported a dream: she was dying of ovarian cancer. Men who appeared very happy entered a submarine which submerged. The patient stated in the same session that she hated to be a woman, and envied men their sexual equipment as well as their superior mental capacities.

While the family history suggests the possibility of genetic factors, the patient's statements fit neatly into the Freudian framework. Since they lack penises, women are doomed to inferiority and envy of men. Furthermore according to Freudian theory, since the penis is so valuable, fear of castration and its resolution through the solution of the Oedipus complex lead to the development of the superego in men. Already castrated, women have less incentive to develop a superego with its concomitant attributes of social awareness and conscience. Women thus are more narrow, more rigid, sociopathic, and self-centered. In addition to these unattractive character traits, women are more vulnerable to sexual disorders, frigid, passive, and masochistic. Women are prone to narcissism, i.e., "driven to rate their charms more highly as a belated compensation for their sexual inferiority."⁶ Because of inherent contradictions in women's relationships to their mothers, women suffer from hysteria, "a characteristically feminine" neurosis, and are also more susceptible to paranoia.⁶ Treatment goals established for women have to incorporate these realities and limitations; a normal woman is something less than a normal man.

In addition, as detailed by Lennane and Lennane, psychological complaints which appear related to women's reproductive functions were also attributed to psychological conflicts.⁵ Furthermore, insufficient interest in such feminine activities as mothering or preference for jobs outside of the home were considered to be indications of masculinity, and hence neurotic.^{6,7}

Case Four—Twenty years ago, a married woman medical student was ordered by the dean to take a leave of absence. He insisted that having become pregnant, she would *naturally* want to be home with her infant, and when she protested, he urged her to seek psychiatric treatment.

Case Five—A teacher who had worked throughout her marriage thought that the marriage was fine until her husband asked for a separation. He had become depressed over the deaths of several friends, said he was a changed man, and had a sexual affair. She agreed stipulating that she would be the one to leave while he remained in charge of house and four teenage sons. Her husband, her sisters, her priest, and her physician said that it was abnormal for a woman to abandon her children and suggested that she consult a psychiatrist.

Such patients were not infrequently treated by psychoanalysis for neurosis. The uncovering of alleged unconscious conflicts was to lead to cure. That this frequently did not happen, Freud himself acknowledged.

While Horney concurred with Freud that women who had conflicts about being women developed neurotic symptoms, she disagreed about the reasons.

The keystone of Freud's thinking was that women were in conflict over their femininity because nature had provided them with unsatisfactory equipment: having a child was only a substitute for a penis.⁶ Horney, a proponent of open systems thinking, believed that the human organism was malleable and in constant interaction with the environment, and that if women disliked being women it was because they lived in male-dominated cultures which devalued women, not because women, a priori, rejected their anatomy or their

physiological functions or social roles.⁷

Influenced by Georg Simmel who stated that Western culture was masculine, Horney argued that penis envy was a male invention foisted on women by men to camouflage male envy of women's childbearing capacities. (Men, according to Simmel, had gained ascendancy at an earlier time in history when their greater physical strength gave them an advantage.)⁸ Horney influenced many psychoanalysts, among them Thompson, who said that "only a man would have thought of it (having a child) in terms of compensation or consolation."⁸

The next case history contains some elements of Horney's views, although Freudians might also claim it.

Case Six—A young male artist said, "Women's bodies are more beautiful than men's bodies . . . because women's bodies are more streamlined." Encouraged to explain his meaning he said, "Women's organs are inside, they are safe . . . it must be wonderful to have the sexual act take place inside . . . having a baby inside you, giving birth must surely be the most exciting human experience . . ."

This well-functioning man consulted a psychiatrist after his wife suffered a psychotic break postpartum. He had no diagnosable mental illness.

SOCIAL AND BEHAVIORAL

Horney bridged the deterministic thinking of the medical and psychologic conceptual models and the open system, and the sociocultural position which is currently popular. Some proponents of the sociocultural view assert that women's position in society and the tasks traditionally imposed on women are inferior; they claim that marriage, motherhood, and home are prisons. Some question the scientific basis for this position. For example, Seiden says that the effect of the American social structure on mental health of women cannot be properly assessed at this time, since "much of the available data lies more in the realm of social commentary than research."⁹

A popular writer frequently quoted in psychiatric literature, Phyllis Chesler, is an enthusiastic proponent of the sociocultural approach. She asserts unequivocally that "most 20th century women who are psychiatrically labeled, privately treated, and publicly hospitalized are not mad. They may be deeply unhappy, self-destructive, economically powerless, and sexually impotent but as women they're supposed to be."³

Extending Simmel's views, Chesler contends that in the Western (male) culture women are slaves and their madness is a revolt against slavery. Men also become mentally ill; perhaps also in revolt against their culturally fostered roles. But even mad men and women suffer differently: men are generally aggressive, women despondent in their symptoms, and these differences also are rooted in culture. When women are hospitalized it is not for treatment but for punishment.³

Chesler's interpretation of the suicide statistics is arresting. It is a fact that women are more likely to *attempt* suicide while men are more likely to *commit* suicide.³ That is, says Chesler, because "Men commit actions; women commit gestures." The completed suicide is paradoxically a successful suicide; women do not kill themselves even if they want to, because women are not trained to be successful at anything.

The next two patients gave different sociocultural explanations for their difficulties.

Case Seven—A 45-year-old woman asked for treatment

because she said that she was wasting her life. The consultation was precipitated by a conversation about current new possibilities for women. She had married at age 32, thinking at the time that "marriage was death." She would have preferred a career but she felt compelled to marry because she had been fired from several jobs, and her mother told her that marriage provided the only real security for women. She had disliked her husband then and still disliked him; she married him because he was a "catch." The patient never worked again. In spite of "great material comfort" and "two lovely children," she has never been happy.

Behind an elegant facade, hid a psychotic woman who remained without acute symptoms because of her protective environment. In the past she had always decompensated under stress. The likelihood of her succeeding in a career was very small. Prognosis for change in therapy was poor.

Case Eight—A 42-year-old married mother of four children sought treatment for depression. A new neighbor told the patient that she was depressed because she was a housewife. The patient thought herself satisfied in her role and attributed the symptoms to other factors, including separation from her parents and friends necessitated by a recent move. But the depression worsened since the conversation. The patient wondered whether the neighbor was right and blamed herself for being comfortable in a subordinate role. The patient's mother had been a labor leader, an active and aggressive public figure. The patient was well-educated having earned graduate degrees; although an excellent student, she disliked school. She married, had four children, and considered herself happy in spite of her mother's subtle denigration of the daughter's life style.

This patient recognized through psychotherapy that, for her, self-realization and autonomy meant staying home and functioning as wife, mother, and community leader, and that her depression was due to other factors.

The behavioral explanations also might apply to these women. In case seven, for example, initially the patient's "feminine" behavior was rewarded, while "masculine" behavior was punished; later, when the social climate turned against "feminine" behavior, the patient developed symptoms. For these two cases as for most of the other cases cited, proponents of other conceptual models also might make plausible claims. The psychoanalysts will say that even with the limited information given, these women's psychological problems are obvious. The biologically oriented will point out that the women in the last two cases are of menopausal age. My conclusions were based on much more information than given here, but the material cited is typical for each patient.

Such women, according to some authors, are victims of a male sexist society and should be treated by women who would encourage them to throw off the shackles of slavery. A therapist committed to this position might have difficulty in allowing that the patient in case report seven is not neurotic even though she does not perceive herself as a slave in the traditional roles of wife and mother and that the liberation from the home might aggravate rather than alleviate the discomfort of the patient in case eight.

Many women patients do seek out women therapists and claim that they fare better with them; anecdotes abound about harm done to women patients by male psychiatrists especially those with a Freudian psychoanalytic background.³ The adverse effects of medical treatments including hormones and psychotropic drugs also are described by critics of the medical model.³

DISCUSSION

Since the *content* of the psychiatric symptoms frequently reflects prevailing mores and fads, patients' complaints taken at face value may be misleading. Common features are noted in the *form* of many mental disorders regardless of the culture in which they appear. Delusions of persecution are recognized and considered to be pathological in diverse cultures; although the persecutors in a remote Ukrainian village might be werewolves or the devil, while in contemporary America they are more likely to be the FBI, the Russians, or rapists.¹¹

Recent emphasis on an analogue of the sociocultural model in the discussions of psychopathology in women may obscure the complexity of the problem and lead to error in diagnosis and treatment, since this model relies heavily on the content of the symptoms.

The conceptual models cited by Lazare, individually or in combination, are useful in assessing the problems of women patients since these models provide a greater variety of etiological and treatment possibilities. Psychiatrists today are familiar with all the conceptual models, and trained in treatment strategies appropriate to each model. Many psychiatrists are flexible and apply one model or a combination of conceptual and hence treatment models are dictated by the patient's needs.

The therapist who rigidly applies a single formula for

etiology and treatment to all patients will make serious mistakes, while the therapist who is trained in all treatment modalities is more likely to make sound judgments.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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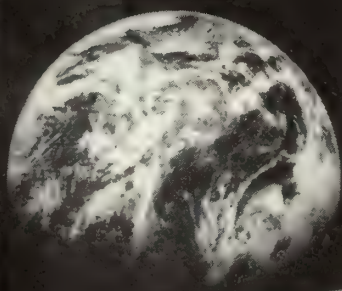
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CASE REPORTS

Chronic Chest Pain and Dyspnea Caused by Occult Constrictive Pericarditis*

JULIUS A. GUTMAN, M.D. and
JACOB I. HAFT, M.D., Newark

Constrictive pericarditis usually is suspected in a patient only when the chest x-ray demonstrates pericardial calcification. However, the diagnosis can be made by logical interpretation of clinical and laboratory data even when calcification apparently is absent. The following is a report of a patient who was disabled for eight years with chest pain and dyspnea by pericardial constriction without radiographically demonstrable calcium. Surgical treatment was curative.

Constrictive pericarditis is a chronic, debilitating, uncommon disease that usually is diagnosed with ease by the findings of heart failure with a normal-sized heart, x-ray evidence of pericardial calcification, ascites, and an echocardiographically thickened pericardium. Occasionally, in the absence of these typical findings, constrictive pericarditis may be difficult to diagnose. Proper diagnosis is of the utmost importance, however, because surgical removal of the pericardium can result in complete and permanent remission of symptoms. The following case report illustrates the specific features of chronic constrictive pericarditis in a patient without the usual clinical findings, and the surgical management of this condition.

CASE REPORT

A 49-year-old female was admitted to Saint Michael's Medical Center because of chest pain and nausea. She had been well until eight years prior to admission at which time she was admitted for severe abdominal pain. Gastrointestinal evaluation, including upper GI series and oral cholecystogram, was normal. Subsequently, she developed congestive heart failure. In 1970, the patient underwent coronary arteriography and cardiac catheterization. Findings included the following: Ra mean = 12 mm Hg, RV = 33/15 mm Hg, PA = 29/18 mm Hg, PA mean = 21 mm Hg, PCW mean = 16 mm Hg, LV = 103/15 mm Hg, and aortic pressure = 96/60 mm Hg. No intracardiac shunt or transvalvular

gradients were demonstrated. Left ventriculography showed normal contractility with no mitral insufficiency or prolapse. Coronary arteriography was entirely normal. Because the right and left ventricle end-diastolic pressures were elevated, the patient was felt to have a cardiomyopathy, even though left ventricular contraction was normal and the chest x-ray showed no cardiomegaly. The patient was treated with digoxin, furosemide, and potassium supplement.

Over the next four years the patient was hospitalized approximately 19 times for recurrent severe chest and abdominal pain. Repeated evaluation demonstrated no further gastrointestinal, pulmonary, or cardiac pathology. Between 1974 and 1978, the patient did not require hospitalization, but continued to have chest pain and exertional dyspnea that forced her to retire from work and prevented her from doing all but light housework. The patient consistently developed increased dyspnea and ankle edema whenever digoxin and furosemide were omitted.

The most recent admission was prompted by a recurrence of severe chest pain and nausea. Past medical history was unremarkable; there was no history of tuberculosis, connective tissue disorder, chest trauma, pulmonary embolus, or illness suggestive of acute pericarditis.

Physical examination demonstrated a well-developed,

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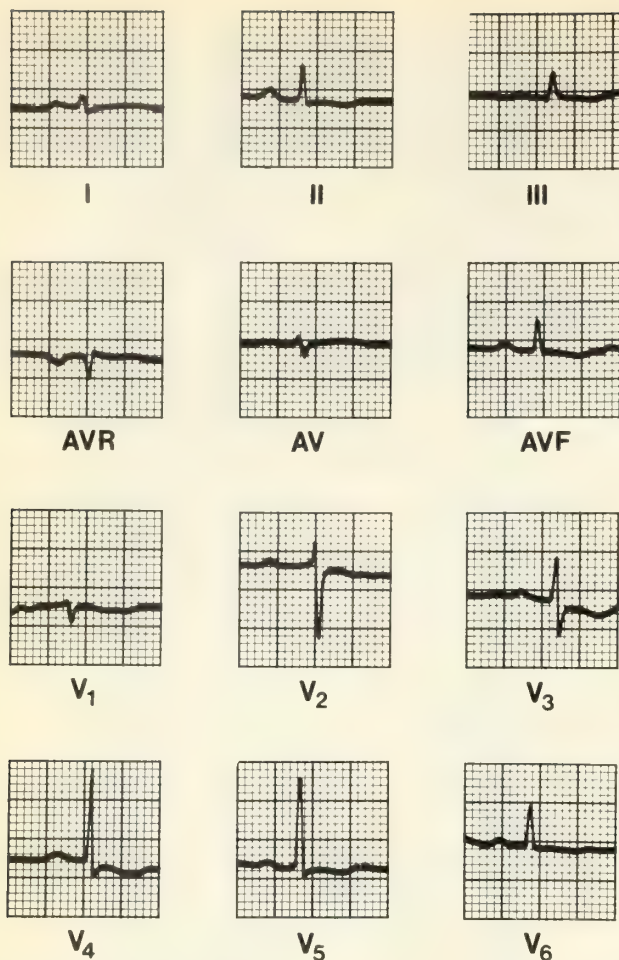


Figure 1—The electrocardiogram shows borderline low voltage and minor ST-T abnormalities.

well-nourished female complaining of anterior chest pain. The pulse and blood pressure were normal without pulsus paradoxus. The neck was supple with large "A" and "V" waves at 60 degrees elevation. The arterial pulse was normal in contour. The lung fields were clear to percussion and auscultation. On cardiac examination the left ventricular impulse was easily palpable at the midclavicular line and was discrete. No right ventricular lift was found. On auscultation, S1 was normal and S2 was single. A prominent, early diastolic acoustic event initially interpreted as an S3 was heard. On abdominal examination the liver was palpable six centimeters below the right costal margin and was non-pulsatile. The extremities were normal with no cyanosis or edema.

The electrocardiogram (Figure 1) showed borderline low voltage and non-specific ST-T abnormalities. The chest x-ray (Figure 2) showed a normal cardiac silhouette without pulmonary vascular congestion, and cardiac series showed no evidence of pericardial calcification. CBC, electrolytes, and SMA-12 were normal. Over the next several days, electrocardiograms and serial cardiac enzymes remained unchanged.

Cardiac fluoroscopy showed no intracardiac or pericardial calcification. The echocardiogram (Figure 3) showed normal left ventricular function without evidence for pericardial effusion or thickening. Systolic time intervals were normal; PEP = 65 msec, LVET = 225 msec, PEP/LVET = 0.29, heart rate = 75/min.

Portions of the catheterization data obtained in 1970 are



Figure 2—Chest x-ray shows no abnormalities.

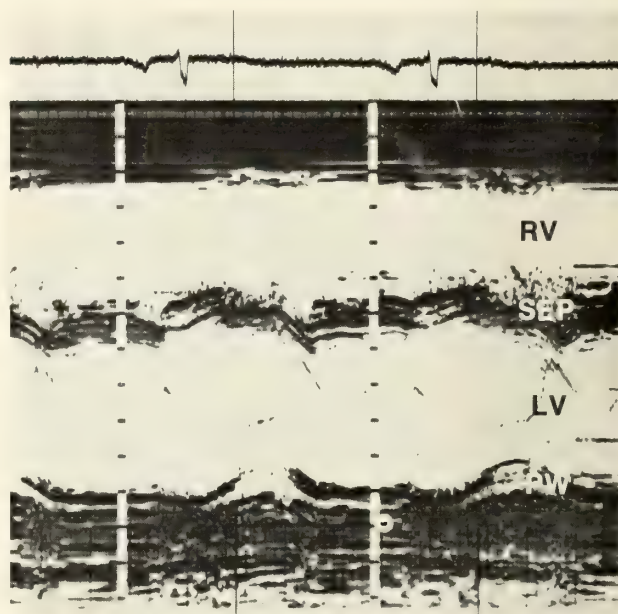


Figure 3—Echocardiogram recorded shortly after admission. Note the normal left ventricular contraction pattern and absence of pericardial thickening or effusion. At this level, with the mitral valve still visible, the apparent paradoxical septal motion may be within normal limits. RV = right ventricular cavity; SEP = interventricular septum; LV = left ventricular cavity; PW = left ventricular posterior wall.

shown in figures 4 and 5. Because of the patient's symptoms, abnormal ventricular diastolic pressure contours, and because constrictive pericarditis was suspected, repeat cardiac catheterization and coronary arteriography were carried out. A summary of the data is shown in Table 1. Coronary arteriography again showed normal coronary arteries and

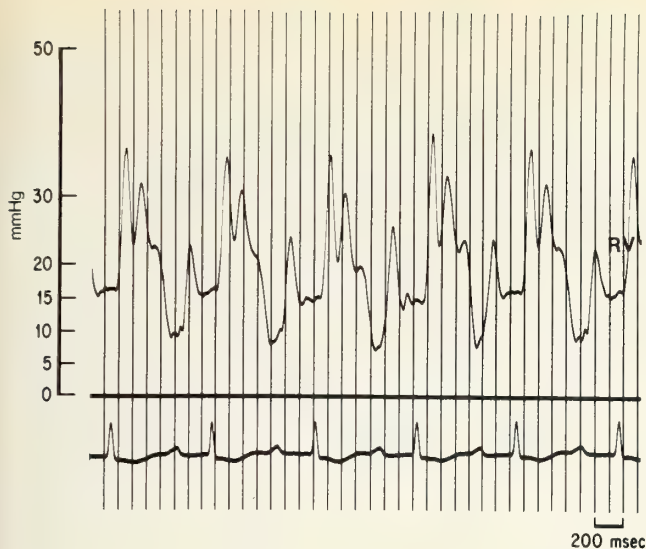


Figure 4—The right ventricular pressure contour demonstrates rapid pressure elevation after early diastolic filling, and an abnormally high end-diastolic pressure (15 mm Hg). RV = right ventricular pressure contour.

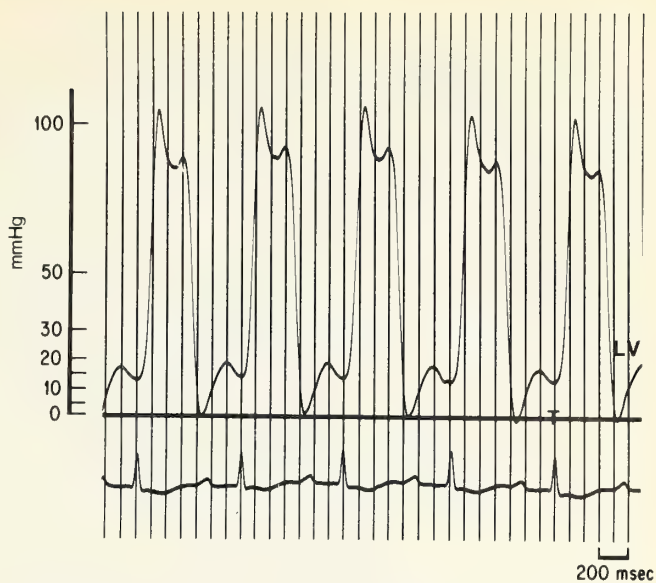


Figure 5—The left ventricular pressure contour shows a suggestion of the "square-root sign," also seen in Figure 4. LV = left ventricular pressure contour.

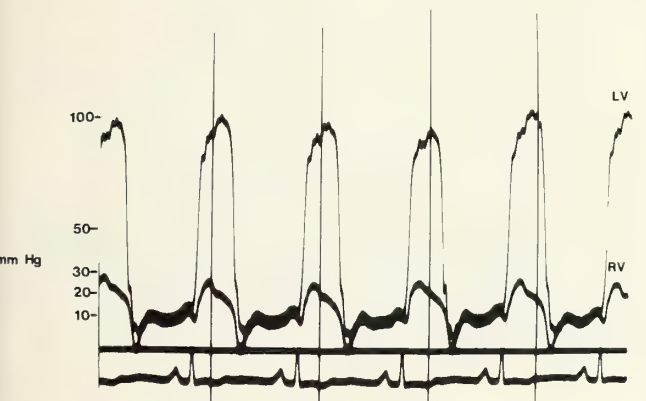


Figure 6—Simultaneous right and left ventricular pressure recordings. Note identical pressure throughout diastole. LV = ventricular pressure contour; RV = right ventricular pressure contour.

normal left ventricular contraction. No calcification of the pericardium was seen during the ventriculogram in either the RAO or LAO projections or during opacification of the coronary arteries in multiple projections. Simultaneous left and right ventricular pressure tracings showed identical superimposable diastolic pressure contours with the suggestion of a square root sign (Figure 6).

Because of these findings the patient underwent thoracotomy. At surgery the pericardium was found to be markedly thickened with visibly impaired motion of the heart. Small amounts of calcification were found at the junction of the inferior vena cava and right atrium and also near the left ventricular apex. The pericardium was successfully stripped from the anterior portion of the heart extending down to the phrenic nerves bilaterally. The inferior vena cava was freed from calcification at the inlet to the right atrium. There was no evidence for acute pericardial inflammation or abnormal pericardial fluid.

Histologic review of the excised pericardial tissue demonstrated chronic inflammation without granulomas or acid-fast bacilli. The post-operative course was entirely uneventful. The patient has not experienced recurrent chest

pain or dyspnea; she reported marked improvement in exercise tolerance and loss of the bothersome neck vein pulsation.

DISCUSSION

Chronic constrictive pericarditis, in the absence of x-ray evidence for pericardial calcification can be difficult to distinguish from restrictive cardiomyopathy, except at surgery¹. In retrospect, our patient's exertional dyspnea and chest pain resulted from chronic pericardial inflammation and restriction to ventricular diastolic filling. The physical examination demonstrated signs of right atrial and right ventricular diastolic pressure elevation evidenced by large jugular "A" and "V" waves without other evidence for tricuspid incompetence. The absence of a right ventricular lift argued against significant pulmonary hypertension as a cause for the high right atrial pressure. The early diastolic sound, initially interpreted as an S3 was probably a pericardial knock; it was not heard postoperatively.

The right ventricular pressure tracing obtained in 1970 demonstrated a suggestion of early right ventricular pressure elevation—the so-called square root sign, although the

Table 1
Catheterization Data Obtained in 1978

Site	Pressure (MM HG)	Normal Values
RA	15/9	< 8/2
RV	30/12	< 30/7
MPA	28/15	< 30/14
PCW	14	< 12
Ao	101/61	< 140/90
LV	105/14	< 140/12
C.I. = 2.4 L/min/m ²		2.4-3.8
A-VO ₂ Diff. = 4.1 Vo 1%		3.5-5.0

A = aorta; LV = left ventricle; MPA = main pulmonary artery; PCW = pulmonary capillary wedge; RA = right atrium; RV = right ventricle

relatively rapid heart rate partially obscured the expected typical initial dip followed by a plateau seen in patients with constrictive pericarditis. Chronic constrictive effusive pericarditis was eliminated as a diagnostic possibility by the echocardiogram which showed no evidence of a pericardial effusion. Although the echocardiogram has been reported to be of value in the diagnosis of pericardial thickening, there yet have not appeared sufficient data in the literature to allow a proper assessment of the sensitivity of the echocardiogram in patients with mild to moderate pericardial thickening that may be sufficient to cause the abnormal physiology and symptoms of constrictive pericarditis. The other major diagnostic possibility, restrictive cardiomyopathy was not eliminated easily; however, at least two findings argued against this diagnosis. First, although the square root sign can be seen at cardiac catheterization in restrictive cardiomyopathy, the left ventricular end-diastolic pressure is usually significantly higher than the right ventricular end-diastolic pressure, especially at end expiration². Left ventricular function appeared normal both echocardiographically and angiographically. This is not surprising in the presence of constrictive pericarditis because, in this abnormality, systolic contraction is frequently normal or even may be exaggerated. It is motion in diastole that is impaired by the constricting pericardium; if the pericardium were to impair cardiac motion during systole, it would be of the outside of the heart, rather than the cavity which is evaluated by angiocardiography. Secondly, the PEP/LVET ratio has been demonstrated to be abnormally high in patients with cardiomyopathy, whereas it is normal in patients with constrictive pericarditis. This finding reflects the normal systolic ventricular function in constrictive pericarditis as opposed to the depressed contractility characteristic of cardiomyopathy³.

The importance of differentiating the two diseases cannot be overemphasized. Restrictive cardiomyopathy is essentially

incurable whereas constrictive pericarditis may be relieved permanently by anterior pericardiectomy. Wychulis *et al.* have noted that this procedure can be accomplished at relatively low risk⁴.

In patients such as this, with chronic incapacitating symptoms suggesting heart failure, it is necessary to pursue all possibilities that may demonstrate a surgically correctible lesion. When no coronary or valvular disease was found and evidence of congestive cardiomyopathy (i.e., cardiomegaly and poor LV contraction) or of obstructive cardiomyopathy (i.e., intraventricular gradients or exaggerated LV contraction) was not present, it was necessary to consider the possibility of constrictive pericarditis. The absence of pericardial calcification on x-ray or of echocardiographic signs of pericardial thickening was disturbing, but the hemodynamic data supported this possibility. In view of the great benefit that the patient would receive if a constricting pericardium were removed, it was felt that exploratory thoracotomy was justified. The high index of suspicion proved correct and the patient has been improved markedly since surgery. This case demonstrates the value of the logical interpretation of available data and the careful analysis of hemodynamic pressure curves in arriving at an elusive diagnosis.

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Spontaneous Rupture of a Renal Angiomyolipoma in Patient with Tuberous Sclerosis

BERNARD PEISON, M.D., BARRY BENISCH, M.D.,
ANTHONY TONZOLA, M.D., and JOHN SARNO, M.D., Rahway*

Spontaneous rupture of a renal angiomyolipoma in a patient with tuberous sclerosis is reported. Although usually asymptomatic, these tumors may produce fatal hemorrhages.

Angiomyolipomas are benign tumors which develop in the kidneys of patients with the tuberous sclerosis complex, where they are usually asymptomatic. Most of the symptomatic renal angiomyolipomas occur in patients without tuberous sclerosis.

The purpose of this article is to report a case of an acute surgical abdomen, due to spontaneous rupture of a renal angiomyolipoma in a patient with the tuberous sclerosis complex.

CASE REPORT

A nineteen-year-old mentally retarded boy, with epileptic seizures and spastic paraplegia due to tuberous sclerosis, was admitted to Rahway Hospital on April 20, 1978, with the clinical appearance of peripheral vascular collapse. Physical examination revealed the patient to be lethargic with a blood pressure of 90/60 mm.Hg, pulse 100 and temperature 100.6 F. Sinus tachycardia was present, but the lungs were clear. The abdomen was distended; diffuse tenderness and absent bowel sounds were noted. Hemoglobin was 8 gm/100 ml; white blood cell count was 17,800 with 72 segmented neutrophils, 5 band cells, 23 lymphocytes. An adequate number of platelets was reported. Because the patient was in shock, he had a portable chest x-ray on admission, which was normal, and portable x-rays of the abdomen which revealed multiple moderately distended loops of the small bowel with diffuse haziness. The appearance was suggestive of intra-

abdominal fluid or partial small bowel obstruction.

A diagnosis of acute surgical abdomen was made and the patient underwent an exploratory laparotomy. There was a large retroperitoneal hematoma and approximately 1000 cc of blood in the peritoneal cavity on the left. The retroperitoneum was entered and a large ruptured tumor mass attached to the left kidney was removed. The right kidney was found to be enlarged probably secondary to compensatory hypertrophy. Following surgery the patient had an intravenous pyelogram which revealed an enlarged, functioning right kidney with no evidence of obstruction. He made an uneventful recovery and was discharged on May 5, 1978.

The removed kidney measured 13.2 x 7.5 x 7 cm. The outer surface was diffusely hemorrhagic and showed multiple raised yellow nodules, varying in size from a few mm to 2.5 cm. The midportion of the kidney showed a large ruptured area with a ragged, irregular, grayish surface surrounded by clotted blood. Section through the kidney revealed it to be replaced largely by multiple circumscribed, rounded, partly

*This case report is from the Department of Pathology, Rahway Hospital, where Dr. Peison is Director of Laboratories, Dr. Benisch is Co-Director of Laboratories, and Drs. Tonzola and Sarno are members of the Department of Surgery. Dr. Peison also is Clinical Assistant Professor of Pathology, New York University School of Medicine; Dr. Benisch is Clinical Assistant Professor of Pathology, Mt. Sinai School of Medicine, New York; and Dr. Tonzola is Clinical Instructor in General Surgery, New Jersey Medical School, CMDNJ. Correspondence may be addressed to Dr. Peison at Rahway Hospital, 865 Stone Street, Rahway, New Jersey 07065.

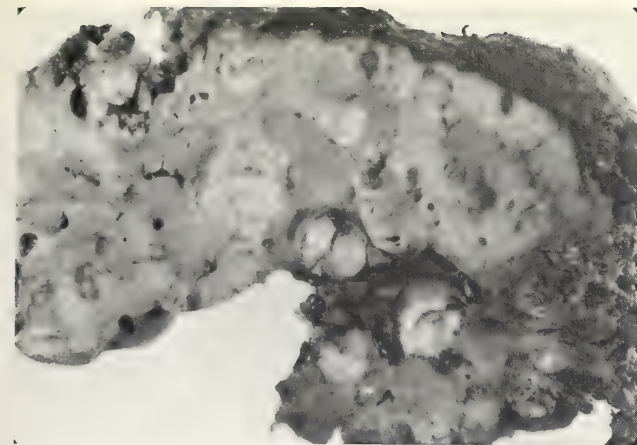


Figure 1—Diffuse capsular hemorrhages due to rupture of renal angiomyolipoma.

hemorrhagic, yellow nodules, ranging in size from one mm to 2.5 cm. (Figure 1). Microscopic examination revealed the renal parenchyma to be replaced by multiple nodules composed of adult fat, masses of smooth muscle containing multinucleated giant cells and numerous thick-walled, tortuous, blood vessels (Figure 2). At the rupture site, many of the blood vessels showed thrombotic material in their lumens, with large adjacent areas of hemorrhage and zones of parenchymal renal ischemic necrosis. Trichrome stain for connective tissue showed the vessels to be markedly hyalinized while the elastic stain revealed most of the vessels to be devoid of the elastic lamina.

COMMENT

Angiomyolipomas are benign tumors often encountered in the kidneys of patients with the tuberous sclerosis complex where they are usually asymptomatic. When found in patients without tuberous sclerosis, they may cause considerable confusion as to their structure, clinical behavior, treatment, and prognosis. Such tumors located within the parenchyma of the kidneys are either single or multiple and vary in size from a few mm to 20 cm in greatest dimension.¹ In patients with tuberous sclerosis the angiomyolipomas are usually multiple and the renal tumors are larger than those of the nontuberous sclerosis group. The size and multiplicity render the tumors in patients with tuberous sclerosis more easily palpable than in patients without tuberous sclerosis.

The literature concerning symptomatic angiomyolipomas of the kidney occurring in patients without tuberous sclerosis was reviewed by Klapproth *et al.* in 1959.² In the pathogenesis of the clinical symptoms the importance of bleeding either into the perirenal tissues or into the substance of the angiomyolipoma has been stressed by several authors.²⁻⁵ The fact that these tumors are prone to hemorrhage is not surprising in view of the structure of the tumors. They are highly vascular and the blood vessels within the tumors are abnormal. The degree of vascularity and the structural rigidity, inelasticity, and tortuosity of the blood vessels of these tumors are factors that predispose them to hemorrhage.

Price and Mostofi¹ reported 30 patients with symptomatic renal angiomyolipomas. None of the patients, as far as could be determined clinically, had any evidence of the tuberous sclerosis complex. Ten of these patients presented as acute

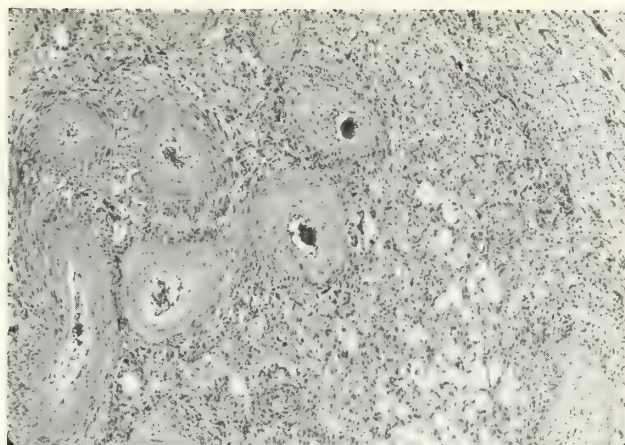


Figure 2—Tumor composed of hyalinized thickened blood vessels, adipose tissue, and smooth muscle. Hematoxylin and eosin X 10.

abdominal emergencies with abrupt onset of pain in the flank or abdomen associated with either a tender palpable mass or with tenderness without a mass in the kidney region. These clinical findings, especially when combined with radiographic evidence of a renal tumor, may be taken as strong suggestive evidence that the patient has an angiomyolipoma of the kidney. If angiomyolipoma is suspected clinically, the patient should be examined for evidence of tuberous sclerosis which is manifested by the clinical triad of convulsive seizures, mental retardation, and adenoma sebaceum.

Angiomyolipomas, whether occurring in a patient with or without tuberous sclerosis, constitute a distinct tumor type believed to be hamartomatous rather than neoplastic. They have proved to be benign, despite apparent local extension beyond the confines of the kidney and a tendency to pleomorphism of some of the muscle cells.

Because of the possibility of spontaneous rupture of this tumor, it is suggested that this complication be suspected mainly in those mentally retarded patients with tuberous sclerosis. In such patients the incidence of renal angiomyolipoma is between 50 and 80 percent.⁶

SUMMARY

Angiomyolipomas are benign tumors often encountered in the kidneys of patients with tuberous sclerosis complex, where they are usually asymptomatic. Most of the symptomatic renal angiomyolipomas occur in patients without tuberous sclerosis. A case of spontaneous rupture of a renal angiomyolipoma in a patient with tuberous sclerosis is reported. Although usually asymptomatic, they have the potentiality to produce fatal hemorrhages.

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Non-Accidental Poisoning with Salicylate

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The reported incidence of salicylate ingestions has dropped. The ages of the children involved also have dropped. Two cases are described of severe salicylism in infancy demonstrating the seriousness of such occurrences and a discussion is presented as to how to prevent future occurrences.

Aspirin remains one of the top five most frequently ingested substances in children under five years of age despite the introduction of safety closures and the limitation on numbers of tablets contained in one bottle.

Although salicylate ingestion of children under 5 dropped from 4.7 percent of all ingestions in 1975, to 4.1 percent in 1976, the age of those affected seems to be decreasing.¹ During the same period, the National Clearinghouse for Poison Control Centers reported a decrease in absolute numbers of children ingesting aspirin, but an increased percentage of young children.

Recently two children under one year of age were admitted to Newark Beth Israel Medical Center (NBIMC) suffering from salicylism, whose *non-accidental etiology* prompted this review.

CASE REPORTS

Case #1—A six-month-old male was admitted to NBIMC with a three-day history of irritability, poor feeding, and a one-day history of fever without vomiting or diarrhea. He was seen by his private doctor one day prior to admission and was found to have otitis media, for which ampicillin was prescribed and aspirin suggested for control of fever. He received six "children's" aspirin tablets in the 16 hours prior to the admission.

On the day of admission, his respiratory rate and temperature increased and he was admitted because of respira-

tory distress and dehydration. On admission, he was in moderate to severe respiratory distress with a respiratory rate of 70 to 80 and a heart rate of 190. His temperature was 106°F. It was estimated clinically that he was 10 percent dehydrated. Initial blood gases revealed a metabolic acidosis (pH 7.16; pCO₂ 15; total bicarb 13.5) and a hypernatremic dehydration (Na=158; BUN=44). Urine on admission gave an intense purple color on Phenistix® testing and his initial salicylate level was 33 mg/dl. He was started on a treatment program of forced diuresis and alkalinization of his urine (2 times maintenance fluids consisting of 1/2 physiological sodium made of NaH CO₃). His course was uneventful and he rapidly recovered from his salicylism.

Case #2—A three-month old male was transferred to NBIMC from another hospital with the diagnosis of salicylism. He had a two-day history of fever for which his mother gave aspirin. Each time he was given the aspirin, the patient vomited and each time his mother would wait a short time and re-administer the aspirin. In the eight hours prior to the admission to the transferring hospital, the child received 1500 mg. of aspirin. At that hospital, a diagnosis of salicylism (aspirin level 60 mg/dl) was made and he was started on intravenous therapy with no attempt at either alkalinization or forced diuresis. He was transferred after 12 hours when he became oliguric, developed a rising BUN, and

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his clinical condition appeared certain to deteriorate.

On arrival at NBIMC, he was febrile, (101°F); tachypneic (RR 80); tachycardic (HR 160) and diaphoretic. His aspirin level was 47. Twelve hours of forced diuresis and alkalinization failed to alter his salicylate level significantly. Hemodialysis was instituted and his clinical condition rapidly improved and salicylate level dropped to 30 mg. Twelve hours after termination of dialysis his aspirin level dropped to 13.

DISCUSSION

Salicylate poisoning from the "therapeutic" use of aspirin products is a preventable illness. Although many physicians, nurses, and public health officials have been warning parents of the damages of *accidental* poisonings, little is ever said of the potential danger resulting from home remedy programs.

The general consideration of the one-and-one-quarter grain *children's* aspirin as "baby" aspirin gives testimony to the attitude that aspirin is safe for young infants. Even the National Clearinghouse terms this preparation "baby" aspirin, a misnomer as all such preparations carry the admonition to use in children under a year, only with the advice of a physician.

Connell² reported 12 infants under one year of age treated for salicylism in seven years at Denver General Hospital all caused by non-accidental ingestion. In each of his cases, a parent or guardian used aspirin to treat infants symptomatically. As in our cases, none of the caretakers was aware of the potential risks involved, although they all knew the consequences of a large "accidental" ingestion.

Buselmeir *et al*³ published a review of methodology for

therapy of severe salicylate intoxication. He pointed out that young children are particularly sensitive to the accumulation of organic anions such as acetoacetate and B-hydroxybutyrate, and thus are at particular risk for salicylism caused by injudicious administration by misinformed parents and guardians.

It would appear that Connell's five-point program of primary prevention of salicylism should be adopted by all practicing pediatricians, clinics and group practices:

1. Inform parents *early* of the hazards of aspirin administration and the admonition against home remedies.
2. Reinforce oral advice with printed material.
3. Orientation of office staff to the *rapidity* of *onset* and *severity* that is the hallmark of infantile salicylism. A clear understanding should be achieved of the use of symptomatic medication.
4. Refer to the one-and-one-quarter grain tablet as *children's* aspirin, never as "baby aspirin".
5. Use an aspirin substitute during the first year of life. Emphasis must be placed on the dangers of single large toxic ingestion of acetaminophen while stressing the low level of toxicity in therapeutic dosage.

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Physicians' Guide to the Laboratory Diagnosis of Viral Infections*

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Laboratory viral diagnosis requires the physician to use all available information. This information comes from physical examinations, history, examination of specimens, virus isolation, and detection of antibody rise. Specimens should be taken early in an illness and kept cold until brought to the laboratory. Interpretation of etiological significance is helped by antibody determination.

It has been estimated that one billion episodes of viral infections occur each year in the United States; most of these are mild and self-limiting. But about five percent (50 million cases) are serious enough to the patient to seek a doctor's care. Until recently, these virus infections had been diagnosed by the exclusion principle; that is, if some etiologic agent such as bacteria or fungi could not be detected, then this illness must be due to a virus. Legionnaire's disease pneumonia was thought to be due to rickettsia or virus until its etiological agent, a gram-negative bacteria, was discovered. In the last few years virus laboratory diagnosis has advanced sufficiently to become an established part of medical practice. This leads to better patient care and accurate prognosis; in the near future, with the advent of antiviral drugs, it will be essential for drug selection.

This guide will explain how the local community hospital virus diagnostic laboratory works and how best to make use of it.

Accurate laboratory diagnosis of viral infections requires that the physician use all the information that can be obtained from the patient. This information can be divided into four main categories:

1. Clinical and epidemiological history, together with a thorough physical examination and supporting laboratory studies.
2. Direct examination of appropriate specimens.
3. Isolation of the infectious virus from appropriate specimens.
4. Evidence of an immune response to the infecting virus.

HISTORY AND PHYSICAL EXAMINATION

Age, sex, and residence may be important in deciding which viruses are likely causes of a given disease. For example—respiratory syncytial virus (RSV) is the viral agent most frequently associated with respiratory disease in early life, especially in the first six months; enterovirus aseptic meningitis is more common among boys than girls; human infections with California encephalitis virus are common in rural Wisconsin and Ohio.

The importance of a careful **physical examination** with supporting laboratory studies cannot be overemphasized. Careful evaluation of **clinical signs** will help narrow the range of diagnostic possibilities. For example, the distribution and character of a vesicular eruption will help to differentiate herpes simplex, varicella, and smallpox; the presence of

*This guide is a revision, with permission, of a guide that had been used at Harvard Medical School by Dr. Michael N. Oxman, now Professor of Medicine and Pathology at the University of California at San Diego. Figure 1 is with permission from *Viral and Rickettsial Diseases Physicians' Handbook*, 4th ed., Ontario Department of Health, Toronto, 1972 and Table 1 is modified with permission from the American Society for Microbiology *Manual of Clinical Microbiology* edited by Dr. Edwin Lennette.

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parotitis will make it much more likely that aseptic meningitis is caused by mumps rather than by an enterovirus; the discovery of a single vesicle in a sick infant with hepatosplenomegaly may lead to a diagnosis of neonatal herpes simplex infection; the analysis of the spinal fluid is extremely useful in distinguishing viral from bacterial meningitis.

Past history is particularly important in the diagnosis of viral infections since, as a general rule, previous infections confer long-lived (usually life-long) homologous immunity. Exceptions include herpes simplex, varicella-zoster, and respiratory syncytial virus.

Epidemiology is an important aid in the diagnosis of viral infections. For example, since the incidence of enterovirus-induced aseptic meningitis peaks in late summer and early autumn, this diagnosis should be made with caution in the month of March; a recently vaccinated sibling is frequently the source of virus in a patient with eczema vaccinatum; focal outbreaks of hepatitis often can be traced to a common source of hepatitis virus.

Travel history is also important in the diagnosis of smallpox, dengue, yellow fever, and others.

Immunization history—knowledge of prior adequate immunization may help exclude such illnesses as paralytic poliomyelitis or rubella. Recipients of killed RSV and measles may have particularly severe and atypical disease when infected with live RSV or measles virus.

Drug and medical history also may be important. For example, disseminated herpes zoster in patients on high-dose steroid therapy, disseminated cytomegalovirus infection in immunosuppressed patients; history of blood transfusions in patients with hepatitis.

DIRECT SPECIMEN EXAMINATION

Before the development of the newer techniques, direct specimen examination, in most cases, would give hints, but could not provide definitive diagnosis. The light microscope was utilized to examine smears, scrapings, biopsies, or autopsy tissue for detection of virus-induced cytological alterations such as inclusions. Now just coming into clinical use are tests that can detect small quantities of viral antigens by direct visualization with the electron microscope or by reaction with specific antibodies labeled with fluorescent dye, enzymes, or radioisotopes. In the future, definitive diagnosis of viral infections within a few hours will depend on the perfection and widespread use of these tests.

a. Light Microscopic Examination

(1) **Stained Smears of Vesicles (Tzanck)**—Scrapings from the base of vesicles are smeared on glass slides, fixed, and stained with Giemsa, H&E, or Wright's stain. The presence of multinucleated giant cells, individual "balloon" cells, and intranuclear inclusions establishes the diagnosis of either herpes simplex or varicella-zoster and excludes smallpox and vaccinia. If the smear instead reveals numerous small (0.3 μ) round particles of uniform size, smallpox or varicella should be suspected (the pox viruses are the only viruses large enough to be visualized by light microscopy). When smallpox is suspected, electron microscopic examination of vesicle fluid and scrapings can provide a definitive answer within hours by revealing virions of large size and unique morphology characteristic of pox viruses. (Smallpox has been eradicated; the last case occurred in 1977 except for a laboratory accident in 1978). A urine sediment stained with Giemsa, H&E, or Wright's stain can reveal the large cells

with intranuclear inclusion bodies diagnostic of cytomegalovirus infection.

(2) **Exfoliative Cytology**—Papanicolaou cervical smears frequently reveal the intranuclear inclusions of herpes simplex infection.

(3) **Biopsies**—Brain biopsy, with the demonstration of typical intranuclear inclusions, is one of the means of making a presumptive diagnosis of herpes encephalitis. Liver biopsy may yield the diagnosis of viral hepatitis.

(4) **Autopsy Sections**—Sections of human or animal brain may reveal the cytoplasmic inclusion bodies (Negri bodies) characteristic of rabies, but fluorescent antibody staining provides a more sensitive and reliable diagnostic technique. The H&E stained sections of lung tissue, read by an experienced pathologist, may suggest cytomegalovirus infection.

b. Electron Microscopic Examination

In hospitals where the electron microscope facility and personnel are available, its use has made possible the rapid diagnosis of many virus infections such as rotavirus in the stools of children with diarrhea or cytomegalovirus in the urine of congenitally infected children. Specimens are treated by the negative stain technique so that in 15 to 30 minutes, viruses from specimens can be visualized and identified by size and morphology, somewhat as the gram stain is used for bacteria.

c. Fluorescent Microscopic Examination

Virus infected cells taken directly from the patient and reacted with fluorescent dye labeled specific antibody reveal virus antigen upon fluorescent microscopic examination, thus providing a definitive diagnosis within two to three hours. Examples include vesicle scrapings from a neonate for herpes simplex infection; influenza and RSV in cells of nasopharyngeal secretions. Lack of good reagents limits the use of this test at present; also, the taking of good specimens by doctors must be practiced so that sufficient cells are obtained for examination. This technique also can be used on cells scraped from infected culture cell tubes to give diagnosis days before the time that cytopathic effect (CPE) or hemabsorption would have developed.

d. ELISA (Enzyme-Linked Immunosorbent Assay)

Virus antigens in infected cells, such as those found in nasopharyngeal secretions, can be detected with great sensitivity by using specific antibodies labeled with enzymes such as peroxidase or phosphatase. When treated with suitable substrates, color changes occur where enzyme labeled antibodies are bound to antigen. These tests usually are carried out in plastic plates containing micro wells. RSV now can be detected with a high level of sensitivity in nasopharyngeal secretions, while herpes simplex virus antigen can be detected by light microscopy in cells scraped from the base of lesions by means of color change due to enzymes labeled antibodies.

e. RIA (Radioimmunoassay)

Viral antigens also can be detected with great sensitivity and specificity by antibodies labeled with isotopes. Hepatitis B surface antigen routinely is detected in blood specimens by this very sensitive assay. Drawbacks to wider use of this method include expensive reagents with a short shelf life, expensive detection equipment, and strict regulatory controls on use of the isotopes.

VIRUS ISOLATION

Until rapid sensitive virus detection methods are perfected, the first aim of the virus diagnostic laboratory is to grow something; the second is to identify what has been grown;

and the last but not least is to evaluate the etiologic significance of any virus which has been isolated and identified.

a. **Virus Isolation**—The isolation of viruses is expensive and time consuming, but absolutely essential for the accurate diagnosis of most viral infections. Although the final answer may not be obtained until long after the patient either has recovered or departed, it is extremely important to obtain a definitive diagnosis. Results from the virus laboratory, by confirming or negating diagnoses which are based on clinical judgment serve an important feedback function to prevent repetition of the same diagnostic mistakes. Furthermore, presumptive laboratory diagnoses may be made within a few days (subject to final confirmation) and will be made even faster as new techniques are developed and put into everyday use. Where the use of toxic metabolic inhibitors such as idoxuridine (IDU) for herpes keratitis and adenine arabinoside (Ara-A) for herpes encephalitis are contemplated, it is important that therapy not be initiated without a vigorous attempt at virologic diagnosis. It is often possible to isolate a cytopathic agent from a vesicle in a neonate with herpes simplex within 24 hours and to make a presumptive diagnosis of herpes simplex on the basis of the characteristic cytopathic effect (CPE) that it produces in tissue culture.

(1) **Choice of specimens** obviously will depend on the clinical syndrome and/or the virus suspected. Table 1 lists specimens that should be taken for specific clinical syndromes. Throat washings or specimens of lung obtained at autopsy are the only worthwhile specimens for the attempted isolation of influenza virus. In aseptic meningitis, a virus may be recovered from other sites such as throat washings or stool for enteroviruses and saliva or urine for mumps. The presence of a normal viral flora sometimes limits the usefulness of nasopharyngeal and stool specimens, and though cerebrospinal fluid often may fail to yield virus in aseptic meningitis, any virus recovered from this source is likely to have etiologic significance.

(2) **Collection of Specimens**—Success in the isolation of viruses is heavily dependent upon proper handling and collection of specimens. Specimens should be collected yesterday, if not sooner *since in most instances maximal amounts of virus are present during the prodrome or on the first day of illness*. Figure 1 shows a general scheme for when to take specimens. Don't waste your time collecting blood for isolation of rubella virus on the fourth day of rash when it is fading. On the other hand, some viruses may be shed for several weeks (enteroviruses in the stool, adenoviruses in throat or stool) or even months (cytomegalovirus in the urine or rubella syndrome) after infection. Once specimens are collected, it is important to consider their stability. *Some viruses are extremely heat and acid labile (cytomegalovirus, rhinoviruses); others are damaged greatly by freezing-thawing (respiratory syncytial virus, cytomegalovirus); while still others are fairly stable (enterovirus often may be recovered from stool after several days at room temperature).* As a general rule specimens should be held at 4° C (refrigerator temperature) in cracked ice if they can be inoculated in less than 24 hours. If they must be frozen, do so at -70°C or lower (dry ice temperature), not at -20°C (standard freezer temperature). Greater stability also is achieved by adding protein to carrying medium. Do not store specimens in dry ice unless they are in sealed ampules, since liberated CO₂ will lower the pH and inactivate acid-labile viruses.

(3) **Choice of propagation system** clearly will depend on the virus suspected. The mainstay of the virology laboratory is

the routine use of two or three different cell culture systems so chosen as to encompass susceptibility to the major clinically important viruses. One common combination is primary monkey kidney (Rhesus, cynomolgous, or green) and a human diploid cell line such as human embryonic lung fibroblast (WI-38). *However, additional nonroutine hosts must be employed for some viruses and will require that the virologist be notified in advance.* For example: most Coxsackie A viruses and arboviruses will be missed if suckling mice are not inoculated; embryonated eggs are more sensitive for the isolation of some strains of influenza virus than tissue culture; rubella virus will not replicate unless special cells such as African green monkey kidney or RK are employed. To date, there are no reliable tissue culture or animal systems in which the agents of Type A and B hepatitis, infectious mononucleosis (Epstein-Barr virus), or rotavirus can be propagated. It should be apparent from the above considerations that the virologist cannot be expected to make a laboratory diagnosis without a clinical history and specimens which are collected carefully and preserved. The specimen labeled "viral studies, please" is a testimony to the physician's ignorance. Furthermore, since appropriate tissue cultures are not always available, advance notice often may permit optimal handling of specimens by permitting the virologist to obtain appropriate test systems.

b. **Identification of Isolate**—Once again, the clinical history helps to narrow the possibilities. Further help may be obtained from

(1) **Differential Host Susceptibility**—An isolate from a throat swab which produces cytopathic effects (CPE) in human embryonic kidney (HEK) but not monkey kidney (MK) is likely to be an adenovirus; most enteroviruses produce CPE in both MK and HEK; a virus from CSF which kills weanling or adult mice but not newborn mice or tissue cultures is most likely lymphocytic choriomeningitic virus; focal CPE in human diploid cells but not in MK after 10 days is most likely cytomegalovirus.

(2) **Type of Cytopathic Effect**—The morphology of infected cell monolayers is often sufficiently characteristic to allow presumptive identification or at least to narrow the choices. Enteroviruses typically produce rounding and shrinkage of cells, which become refractile. Adenoviruses yield grape-like clusters of cells which look agglutinated. Herpes viruses cause cells to swell with a typical ballooning degeneration. Respiratory syncytial virus, measles, and some parainfluenza viruses give rise to syncytial multinucleated giant cells, while many other orthomyxovirus (influenza) and paramyxovirus (parainfluenza) may produce little or no cytopathic effect. Their presence in the latter circumstances is recognized by *hemadsorption* (sticking of erythrocytes to the surface of infected cells), and when an orthomyxovirus is suspected, the cells are checked by adding red cells to the cell culture every three or four days. The evaluation of cytopathic effects is facilitated by fixing with the proper fixative and staining the infected cultures with H&E or Giemsa. This may reveal characteristic inclusion bodies, the presence of which often facilitates presumptive identification (i.e., cytomegalovirus, measles, herpes simplex). Finally, rubella virus typically produces no cytopathic effect in many susceptible cell cultures, nor will the rubella infected cells hemadsorb. Replication of rubella virus is recognized by the phenomenon of *interference*; the infected cells are challenged with another virus, such as Echo 11, which would ordinarily destroy the cell monolayer but whose replication is prevented by prior infection with rubella virus.

TABLE 1. Specimens for virus isolation and types of serological tests employed for diagnosis

Clinical manifestations and common etiological agents	Source of specimen for virus isolation		Serological Tests	
	Clinical	Postmortem	Usual ^a	Special ^a
<u>Upper respiratory tract infections</u> Rhinovirus Mycoplasma Parainfluenza	Throat swab or nasal secretions		NA CF CF, HI	(Nt)
Adenovirus Enterovirus Reovirus	Throat swab and feces		CF, HI, Nt NA Hi, Nt	(Nt, HI)
<u>Lower respiratory tract infections</u> Influenza Adenovirus Parainfluenza Mycoplasma Respiratory syncytial virus	Throat swab and sputum Nasopharyngeal secretions	Lung, bronchus, trachea	CF, HI, CF, HI, Nt CF CF CF	 (FA)
<u>Pleurodynia</u> Coxsackie virus	Feces and throat swab		NA	(Nt)
<u>Cutaneous and mucous membrane diseases</u> <u>Vesicular</u> Smallpox and vaccinia Herpes Simplex Varicella-zoster	Vesicular fluid and scrapings	Lung, liver, spleen, brain	CF, HI CF, Nt CF	(FA) (FA) (FA)
Enterovirus	Vesicle fluid, feces and throat swab		NA	(Nt, HI)
<u>Exanthematous</u> Measles Rubella Enterovirus	Throat swab Feces and throat swab		CF, HI HI, CF NA	(Nt, FA) (Nt) (Nt, HI)
<u>Parotitis</u> Mumps	Throat swab and urine		CF, HI	
<u>Central Nervous System Infections</u> Enterovirus	Feces and CSF _b	Brain tissue, Intestinal contents	NA	(Nt, HI)
Herpes Simplex Mumps	Throat swab and CSF	Brain tissue	CF CF, HI	(Nt, FA) (Nt)
Lymphocytic Choriomeningitis	Blood and CSF	Brain tissue	CF	(FA)
Arbo Viruses Western equine encephalitis Eastern equine encephalitis Venezuelan equine encephalitis	Blood and CSF	Brain tissue	CF, HI CF CF	(Nt) (Nt) (Nt)
California Encephalitis St. Louis Encephalitis Japanese B Encephalitis	Usually not possible to isolate virus from clin. specimen	Brain tissue	CF CF CF	(Nt) (Nt) (Nt)
Rabies	Saliva	Brain	Nt, FA	
<u>Severe undifferentiated febrile illnesses</u> Colorado tick fever Yellow fever Dengue	Blood	Liver, spleen, lung, brain	CF CF CF	
<u>Congenital anomalies</u> Cytomegalovirus	Urine and throat swab	Kidney, lung, other tissues	CF	(FA)
Rubella	Throat swab and CSF	Lymph nodes, lung spleen, other tissues	HI, CF	(Nt, FA)
<u>Hepatitis</u> Virus B (HB Ag)	Agent not recoverable	Agent not recoverable	RIA, CF CIEP	
<u>Mononucleosis</u> Epstein-Barr herpes virus	Throat swab (only in research lab)		FA	(Nt)

a. Usual indicates types of serological tests commonly performed; special indicates serological tests which may be used for special studies not feasible as routine diagnostic procedure. NA Serological tests either not available or generally not feasible as routine diagnostic procedure. Nt, neutralization; CF, complement fixation; HI, hemagglutination inhibition FA, fluorescent antibody; CIEP, counterimmunoelectrophoresis; RIA, radioimmunoassay.

b. Cerebrospinal fluid

(3) **Physical and Chemical Properties**—A presumptive laboratory diagnosis usually can be achieved by an educated guess based upon clinical features and cytopathic effect. This then can be confirmed by serologic methods (see below). Biophysical properties are also useful in routine diagnosis, especially with unusual or problem isolates. Obviously such properties as the number of capsomeres or cubical versus helical symmetry are not routinely determined. However, *size*, the presence or absence of a *lipid envelope* and the type of *nucleic acid* may be determined readily.

(a) **Size**—In practice this is determined by passing the infected cell culture fluid through filters of three limiting pore diameters: 300 nm, 100 nm, and 50 nm. If the virus passes a given filter, the filtrate is capable of producing infection when inoculated into new cell cultures. Such a procedure can, for example, distinguish herpes virus from adenovirus since only the latter will pass through a filter with a 100 nm limiting pore diameter.

(b) **Lipid envelope**—The presence of a lipid envelope may be determined by adding ether to the cell culture harvest, bubbling off the ether with nitrogen gas and reinoculating fresh cultures. For example, herpes virus (which are enveloped) lose infectivity after ether treatment whereas adenoviruses (which are not enveloped) do not.

(c) **Nucleic acid**—Cell cultures are pre-incubated with iodo- or bromo-deoxyuridine or with cytosine arabinoside before adding the unknown virus isolate. These inhibitors, which block DNA but not RNA synthesis, permit us to determine the nucleic acid type of the virus. They only will block the cytopathic effects of DNA viruses.

(4) **Serologic Identification**—All of the above methods for the identification of viruses are only presumptive. Definitive identification of virus isolates depends on typing the unknown virus or viral antigens with immune serum of known specificity. In practice the most frequently used serologic tests are (depending on the virus suspected) complement fixation (CF), hemagglutination inhibition (HI), or neutralization (N). For example: a presumptive herpes virus may be confirmed by N and no further identification is necessary; a presumptive adenovirus may be identified as an adenovirus by CF, since all 33 serotypes share a common CF antigen. Patterns of hemagglutination of rbc's of different species then are used to place the isolate in one of the four major adenovirus groups. Final serotype identification is achieved by either HI or N, using antiserum to individual serotypes within the major group. An isolate from cerebrospinal fluid which is presumptively either Coxsackie group B or Echo usually is identified by N since CF antigens are neither sufficiently broadly reactive to detect all members of the group, nor sufficiently specific to identify individual serotypes. Since there are six serotypes of Coxsackie B and about 31 Echo serotypes, it is clearly not practical to do 37 separate neutralization tests. The problem is solved by using antiserum "pools" in a combination pattern so designed that each serotype is included in more than one pool. It is thus possible to test a virus isolate against more than 40 type-specific antisera using only eight pools of sera in a single test.

c. **Etiological Significance of Virus Isolation**—The significance of a virus isolate depends on a number of factors. Many viral infections, especially in children, are *intercurrent* and completely asymptomatic. Thus the cause and effect relationship between virus and disease must be judged in the light of the clinical syndrome and the particular virus isolated. For example: an adenovirus may be shed intermittently in the throat or feces for many months and, therefore,

its isolation from the throat of a patient with pharyngitis does not necessarily imply that it is the cause. The site of isolation is also important: the isolation of a Coxsackie virus from the cerebrospinal fluid of a patient with meningitis or from the pericardial fluid of a patient with pericarditis has greater etiologic significance than the isolation of the same virus from feces since enterovirus may be shed continuously for several weeks following completely asymptomatic infection. Still further interpretive problems are created by *latent* viruses. The classic example is herpes virus which may be reactivated nonspecifically by an acute febrile illness and in no way be related to the cause of the fever. Further evidence for etiologic association is provided by signs of tissue destruction and host response. For example, cytomegalovirus (CMV) inclusions are not infrequently found at autopsy in the lungs of immunosuppressed hosts, yet there is usually no evidence of a leukocytic reaction to the virus; CMV infection is much more common than pneumonia due to CMV. Additional supportive evidence for etiologic association is provided by evidence of *antibody production*.

SEROLOGIC DIAGNOSIS (EVIDENCE OF IMMUNE RESPONSE)

a. **General Principles**—The detection of virus infection by serologic means is based upon the principle that most viruses elicit the production of specific antibodies. *Serology* offers an advantage over virus isolation: it is performed cheaply and rapidly. However, one must wait until convalescence to make the diagnosis (see figure 1) and, furthermore, it does not distinguish intercurrent infection from causal infection (once again, the demonstration of recently elaborated antibodies to an enterovirus is only supportive evidence that the virus was the cause of aseptic meningitis). Especially in the absence of virus, serology on a single serum specimen is usually worthless since it cannot distinguish recent infection from infection in the distant past. An exception is one serum serology for Epstein-Barr virus in which a series of fluorescent antibody tests can determine recent or past infection. Furthermore, the height of the antibody titer in a single specimen is usually no guarantee of recent infection, particularly with N or HI antibodies, which persist for many months or years. It is therefore necessary to draw **both** acute and convalescent sera and demonstrate a rising titer to a specific virus. (See figure 1). A significant rise usually is taken to be four fold or greater when the two sera are run in the same test, i.e., 1:16 to 1:64. In general, a virus isolation should be interpreted with caution unless there is concomitant development of a rising antibody titer to the same virus. Exceptions: recurrent herpes simplex infection, especially in adults, often is associated with high, constant levels of antibody; adenovirus infections, especially in infants, may be associated with a rise in HI or N antibody, but not CF antibody or vice versa or there may be no demonstrable antibody response at all; cytomegalovirus infection in either the newborn or the immunosuppressed adult may be unaccompanied by antibody response. The timing of serum collection is critical. Obviously, if the acute serum is drawn too late, antibodies already may be approaching maximal levels and it may not be possible to demonstrate a rise. Acute phase serum should be drawn immediately—it *cannot be drawn too early!* The convalescent phase serum is normally collected two to three weeks later although with some viruses (e.g., respiratory syncytial virus in infants) it may be necessary to wait up to six weeks.

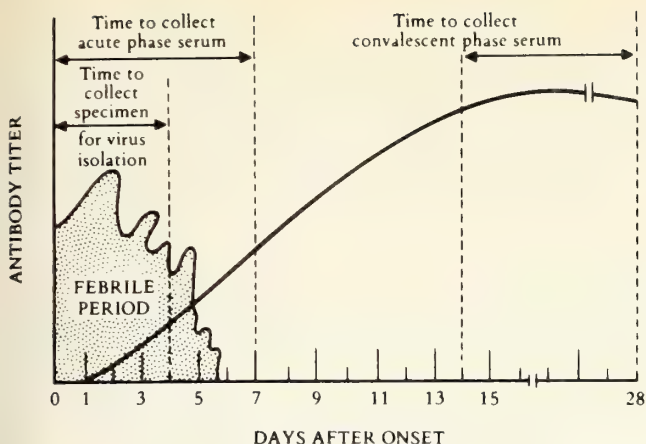


Figure 1—Optimal time for collecting specimen with regard to illness.

b. Available Tests—The most commonly used tests are complement fixation (CF), hemagglutination inhibition (HI) and neutralization (N). In the *CF test* serial, twofold dilutions of unknown acute and convalescent sera are reacted with a standard amount of *known viral antigen* plus a standard small amount of complement. The three-component system is incubated overnight at 4°C. Fixation of the complement occurs if antigen-antibody complexes have formed. Residual complement then is assayed by adding a standard amount of sheep red blood cells previously sensitized with anti-sheep rbc hemolytic serum. The test is read after further incubation for one hour at 37° C. Hemolysis, indicating the presence of unfixed complement, occurs when no viral antigen-viral antibody reaction has occurred. Conversely, absence of hemolysis indicates fixation of all the available complement by the viral antigen-viral antibody complexes and shows that antibody to that antigen was present at that particular dilution. The CF titer of the serum is the highest dilution possessing detectable antibody. The *HI test* is conceptually simpler. Some viruses possess the capacity to agglutinate red blood cells of various animal species, and this reaction may be prevented by specific immune serum. Serial twofold dilutions of acute and convalescent sera are reacted with a standard amount of known viral hemagglutinating antigen overnight and then a standard amount of red blood cells added for a further one hour. The highest dilution inhibiting hemagglutination is the serum titer. In the *neutralization (N) test*, serial dilutions of serum are mixed with a standard amount of known virus and, after a half-hour incubation period, the mixture is inoculated into susceptible cell cultures. The N titer is the reciprocal of the highest dilution preventing CPE. Newer tests for antibody detection still in developmental stages include enzyme linked immunosorbent assay (Elisa), immune adherence hemagglutination (IAH), counterimmunoelectrophoresis (CIE), immunofluorescence, (IF) and radioimmunoassay (RIA).

In practice, diagnostic serology involves two choices: (1) Which virus should be tested for? (2) Which serologic method should be employed? As with virus isolation, the choice of viruses to be tested for involves some knowledge of the clinical history. A request for "viral antibody screen" is manifestly absurd since it is feasible only to test for the most suspect viruses. In the case of aseptic meningitis, for example, it would be necessary to screen for more than 40 polio, Coxsackie, and Echo viruses! However, the patient's sera might reasonably be tested against the particular enterovirus

serotype isolated from his feces or against two or three serotypes known to be prevalent in the community at that time. The second choice (which serologic test?) involves several considerations. Table 1 shows the usual tests used for each virus. The CF and HI tests are relatively inexpensive and more rapid than the N test. However, the N test is generally the most specific and is applicable to nearly all viruses while HI tests are applicable only to those viruses which cause hemagglutination. CF antibodies are, in general, the least specific and most transient (they usually fall within several months of infection) while HI and N antibodies often persist, usually for many months or even years, with little change in titer.

COLLECTION OF SPECIMENS FOR VIRAL ISOLATION

General Points:

- (1) Collect specimens as aseptically as possible since cell culture fluid is also a rich medium for the growth of bacteria which may destroy the cell culture and thus preclude virus isolation.
- (2) Keep all specimens *packed in crushed ice* since most viruses are heat labile.
- (3) Specimens should be collected as early in the course of illness as possible because in most cases maximum quantities of virus are present only during the prodrome or on the first day of illness.
- (4) All specimens for virus isolation immediately should be hand carried in *crushed ice* to the Virology Laboratory for inoculation into cell culture.
- (5) If a specimen such as CSF is obtained at a time when the Virology Laboratory is not open, it should be held in crushed ice in the refrigerator until morning. As a general rule specimens should be held at 4° C in ice if they can be inoculated in less than 24 hours. If they must be frozen, do so at -70° C or lower, not at -20° C.

Specimens:

- (1) **Blood**—Citrated whole blood (3 to 5ml) is used for attempts to isolate virus from the buffy coat, i.e., cytomegalovirus. For serology, 6 to 10ml. of blood should be drawn into a red or marble-topped tube. Do not freeze whole blood since resultant hemolysis will prove toxic for tissue culture and will interfere with serological tests.
- (2) **Nasopharyngeal, Throat, Rectal, Vaginal and Eye Swabs**—Place immediately in virus carrier medium. Virus carrier medium, obtained from the virology laboratory and kept in the ward refrigerator, consists of a sterile buffered salt solution with added serum to stabilize the virus and with antibiotics to suppress growth of bacteria and fungi. These swabs never must be allowed to dry because drying inactivates many viruses.
- (3) **Feces**—5 to 10 gms. is preferable to a rectal swab since only a small amount of virus may be present.
- (4) **Body Fluids**—(CSF, pericardial, pleural, and so on). Collect several ml. in a sterile tube in crushed ice.
- (5) **Urine**—Collect 10 to 30 ml. of urine (clean-voided midstream or catheter specimen) in a sterile tube in crushed ice.
- (6) **Vesicle Fluid**—Aspirate with a tuberculin syringe which already contains about 0.3 ml. of virus-carrier medium. Then cap the syringe and send it properly labeled and packed in ice to the virology laboratory.
- (7) **Autopsy (or Biopsy) Materials**—Collect as soon as possible postmortem in a sterile tube in crushed ice. Choice of tissue (brain, liver, lung, and so on) is dictated by the clinical syndrome and gross pathology. When autopsy specimens

cannot be cultured immediately, they should be frozen at -70°C (not at -20°C).

N.B. Each specimen should be labeled carefully with patient's name, nature of specimen, and time and date obtained. *Never wrap an unlabeled tube in a laboratory slip.*

DIAGNOSIS OF CONGENITAL INFECTIONS

The diagnosis of congenital infection by toxoplasma, rubella virus, cytomegalovirus, or herpes simplex virus (members of the "Torch" complex) may be established by means of special serological tests. These require a minimum of three ml. of serum (six to seven ml whole blood) from the infant and the mother at birth (or as soon thereafter as possible) and a second comparable sample from the infant and from the mother four to six months later.

SUMMARY

Until recently, virus laboratory diagnosis was made only at the state laboratory primarily to gain epidemiological data for public health purposes. With the advent of local community hospital-based diagnostic virology laboratories, viral diagnosis has become an established part of medical practice providing better patient care and prognosis. For the physician to get the most value out of the viral diagnostic laboratory, he must be aware that accurate laboratory diagnosis requires that all the information that can be obtained from the patient be utilized.

First, the physical examination and history can help define the class of viruses that may be probable in this case. Next, direct examination of patient specimens can narrow the possibilities further. Use of newer techniques when available sometimes can provide definitive diagnosis within hours. Virus isolation, the third source, usually takes days to complete. Specimens must be collected early. Once isolated, virus must be identified realizing that definitive identification of virus isolates depends on typing the unknown virus with immune serum of known specificity. Supportive evidence for the etiological significance of an isolate can be provided by evidence of an antibody response. This fourth source of information takes longest to obtain because convalescent serum can't be collected until 14 to 21 days after the acute serum.

Selection of antigens to be tested for is important, since serological screens for all virus types is impractical due to the

high expense. The most commonly used tests include complement fixation (CF) hemagglutination inhibition (HI), and neutralization (N). Finally, all specimens taken for virus isolation must be kept cold until they are brought to the laboratory.

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Holter Monitoring

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Holter monitoring (ECG ambulatory monitoring) is a technique whereby a patient's electrocardiogram is recorded on magnetic tape continuously for 24 hours or more. The tape then can be reviewed at 60 to 120 times the real time (the actual recording time) and by means of electronic circuitry, abnormalities of rhythm, S-T segment shifts, T wave and QRS changes can be detected and automatically or manually recorded. Originally only one lead was recorded on conventional cardiograph paper; currently most machines record two leads simultaneously. Usually the electrodes are so placed that a modified V5 and L2 are recorded, but these cannot be compared directly with V5 and L2 of the conventional 12-lead ECG.

The principal application of this ECG technique is the detection of disturbances of rhythm that are either asymptomatic or symptomatic but not present during the period that the routine ECG is taken. Holter monitoring may be especially valuable in the differential diagnosis of atypical chest pain. When the monitor records typical S-T depression, especially when associated with chest pain, the diagnosis of angina pectoris secondary to coronary artery disease is supported. The absence of ECG changes during an episode of chest pain suggests that the pain is non-cardiac in origin, although technical factors such as inadequate electrode placement also may result in the absence of recorded S-T segment changes.

Patients with a history of syncope, those with undiagnosed palpitations, and those at high risk of sudden death are

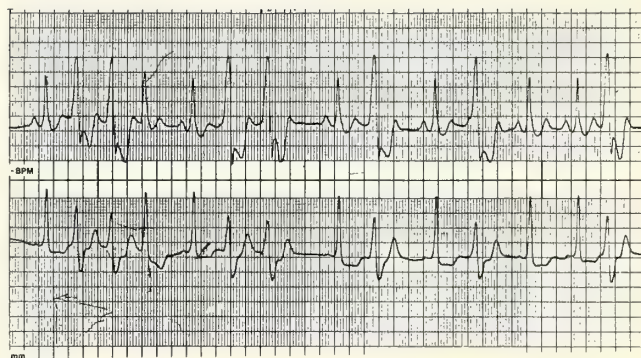


Figure 1—Two Holter monitor leads recorded simultaneously during a period of increased ventricular irritability. Beat one is a conducted beat; beats 2 and 3 are premature ventricular depolarizations followed without pause by conducted beat 4. This sequence is repeated in beats 5, 6 and 7 but beat 8 appears only after a compensatory pause. Frequent premature ventricular depolarizations are seen in the remainder of the tracing.

monitored most frequently by this method. Many arrhythmias appear only sporadically and prolonged monitoring is necessary for their detection. Second and third degree A-V block and periods of sinus arrest may appear only for brief periods; the demonstration of the arrhythmia on the

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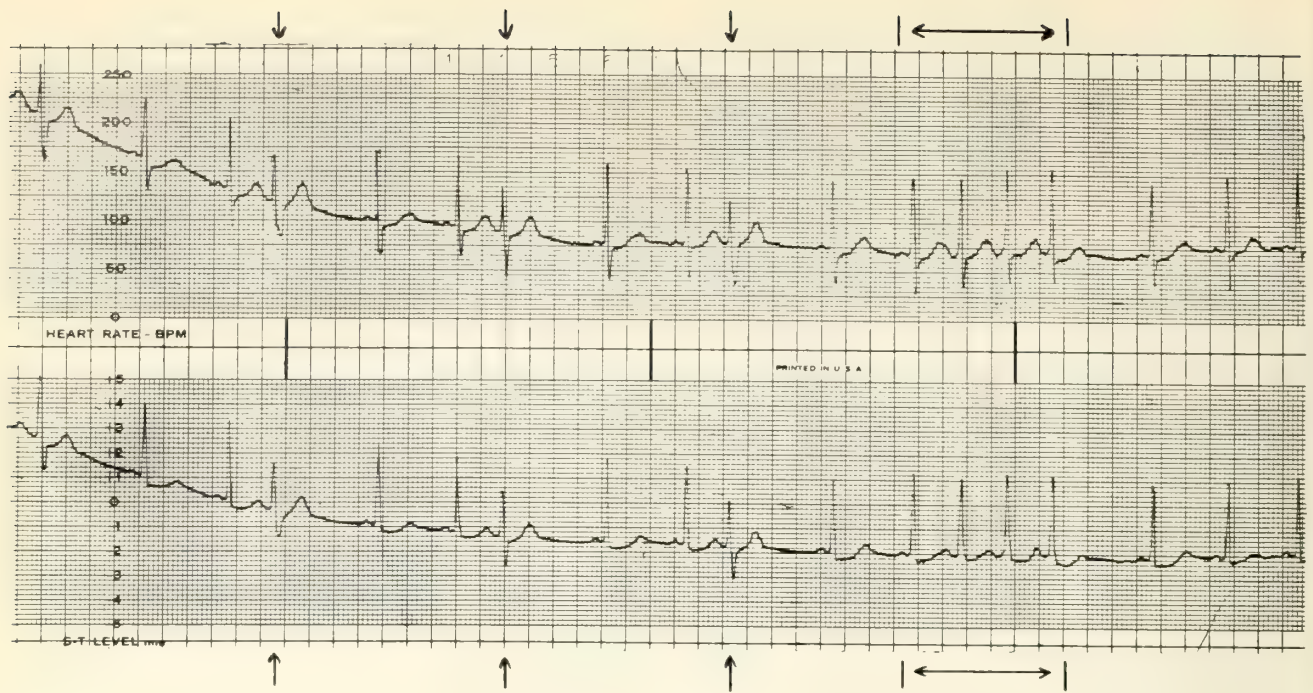


Figure 2—A rhythm strip selected from the 24-hour Holter recording shows regular sinus rhythm with a P-R interval of 0.12 second. Top and bottom strips were recorded simultaneously. Frequent atrial

premature beats are seen. Toward the end of the strip there is a short run of three atrial premature depolarizations in a row, the only such run found.

monitor strip will confirm the need for a pacemaker. Life-threatening paroxysmal tachycardias may appear for only a few beats and their detection by this method leads to correct therapy. Intermittent multifocal PVC's, couplets or triplets in a patient at risk may require urgent therapy (case one). Conversely, the Holter monitor strip may confirm the benign nature of a symptom-producing arrhythmia (case two).

CASE ONE

The patient was a 64-year-old male who had a myocardial infarction two and a half weeks prior to the monitoring. During the acute episode he had several bouts of ventricular tachycardia which were controlled with intravenous lidocaine followed by oral procainamide (Pronestyl®). This drug was discontinued after he had been in regular sinus rhythm without premature ventricular depolarization for one week. Another week later, prior to discharge, the electrocardiogram was monitored for 24 hours by the Holter technique to determine whether it was safe for him to be discharged

without antiarrhythmic medication.

Most of the monitor tracing showed regular sinus rhythm with occasional unifocal ventricular ectopic beats. However, as shown in figure 1, couplets of ventricular premature depolarizations were present as well as frequent unifocal ventricular premature depolarizations. On the basis of these findings, procainamide again was administered, maintenance doses prescribed, and the patient discharged.

CASE TWO

The patient was a 46-year-old female with the complaint of frequent palpitations. She had no other cardiac symptoms and no history of prolonged tachycardia. Routine physical examination, ECG, and chest x-ray were normal. No premature beats were detected. A Holter monitor study was obtained to evaluate the patient's symptoms (figure 2). On the basis of these findings the patient was assured of the relatively benign nature of her symptoms. No antiarrhythmic medication was prescribed.

Anorexia Nervosa

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Anorexia nervosa is an illness appearing chiefly in adolescent girls shortly after the onset of puberty. It occurs approximately ten times more frequently in girls than in boys. While it may begin just before puberty or later in adolescence, it seldom begins after the age of 20. Associated with reduced gonadotropin production, pubertal changes are delayed or reversed. In girls, it invariably results in amenorrhea. The cardinal sign is precipitous weight loss in an individual whose growth previously has been satisfactory. Growth in stature generally continues despite weight loss of six months, a year or more. The weight loss is the result of zealous self-imposed dieting and continues in the face of hunger, admonitions, and threats.

After the description of the syndrome by Sir William Gull in 1868, anorexia nervosa was long considered a medical rarity. Few professionals took serious interest in it until the 1930's when John Berkman of the Mayo Clinic undertook the intensive study of these patients and developed a rational approach to treatment based on dietary principles. Prior to that time, patients with anorexia nervosa often were misdiagnosed as having primary pituitary disease.

There has been much popular interest in the disorder of late with speculation about its prevalence and cause and discussion about diagnosis, treatment, and the dietary principles that apply. Controversial opinions continue to be expressed.

PREVALENCE

It is widely held that anorexia nervosa is becoming more prevalent. It is more often reported in affluent societies than in underdeveloped countries and is said to occur more commonly in upper and middle than in lower class families. However, reliable epidemiologic surveys are not available. Data accumulated at the Mayo Clinic over the 32-year period from 1944 to 1975 indicate that from 40 to 80 patients per year consistently have been diagnosed as having anorexia nervosa. This represents a total of 1,781 patients of whom 91 percent were female and 9 percent male.¹

CAUSE

Is the disorder a psychologic or a physiologic illness? Two points of view exist. One view holds that disturbed patterns of family relationships adversely influence the child who will develop anorexia nervosa and that the child never develops an adequate sense of autonomy and effectiveness.² The other view holds that an immature pattern of hypothalamic functioning interferes with the normal maturational process at puberty.³ Study of the neuroendocrine mechanisms is an active area of research.⁴ The weight of evidence suggests that anorexia nervosa is a bio-psychosocial phenomenon with influences from several spheres. The importance of one or another of these influences varies for individual patients. Some individuals may have the metabolic predisposition to develop the disorders. An hereditary influence is possible, as some twins, other sibling pairs, and parent-child pairs both with the disorder have been reported. Early feeding patterns and later attitudes in the family around food may further set the stage for the illness. Finally, societal influences play an important role with the widespread emphasis on diets and on the desirability of being thin.

DIAGNOSIS

Once the weight loss is well advanced, the diagnosis is not difficult to make. Emaciation is far more severe than other physical findings would justify. With a few exceptions, the signs are essentially those of a healthy person subjected to starvation.⁵ Bruch identified psychological characteristics associated with the illness as disturbance of body image, misperception of internal physiologic stimuli, a sense of ineffectiveness, hyperactivity, and denial of fatigue. She identified a primary form of anorexia nervosa in which

*Reprinted with permission of *Contemporary Nutrition* 3:8 (August) 1978, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Lucas is Chief, Section of Child and Adolescent Psychiatry, Mayo Clinic and Professor of Psychiatry, Mayo Medical School, Rochester, Minnesota and may be addressed there.

relentless pursuit of thinness is the driving motivation and atypical forms, including other types of psychogenic malnutrition, depressive illness and schizophrenia.² The physiologic changes depend on the patient's age, the stage of illness, the degree of malnutrition as well as on the particular dietary habits established. In addition to marked loss of weight, somatic changes regularly include pallor, dryness of the skin and hair, lanugo hair, cold hands and feet, bradycardia, hypotension, marked cold intolerance, diminished sweating, and amenorrhea in females.¹ Some patients have episodic overeating and self-induced vomiting leading to erosion of tooth enamel. In others, laxative and diuretic abuse may result in electrolyte imbalance. When the illness is far advanced, body fat tissues have been depleted and there may be muscle wasting as in other forms of protein-calorie malnutrition. Hyperactivity gives way to weakness, apathy, and depression.

Early identification is important to effective treatment and to the prevention of physiologic and psychologic complications. Failure to continue to gain weight during the active preadolescent growth phase or the sudden loss of weight in adolescence should alert the physician. Associated with personality changes such as irritability, increased compulsiveness, striving for perfection, physical overactivity and withdrawal of social interests, it may signal the onset of anorexia nervosa.

There is no diagnostic laboratory test and no typical laboratory profile for anorexia nervosa. The laboratory findings reflect the severity of malnutrition and are of greatest help in documenting the degree of physiologic reaction to under-nourishment. Basal metabolic rate is diminished. Endocrine status reflects chiefly the state of the body's adaptation to stress. Until the illness is far advanced, the protective mechanisms of the body maintain relatively normal hematologic, urinary, and blood chemistry values.¹

TREATMENT

The difficult personality features of these patients, the complicated treatment, and the long course of illness leading sometimes to death, have made these patients anathema to general physicians and psychiatrists alike.

Treatment approaches have ranged from those focusing purely on refeeding or behavior modification aimed at gaining weight to psychotherapeutic approaches ignoring the malnutrition. Coercive methods may restore weight but they are never indicated.^{6,7} Psychotherapy alone may be sufficient if malnutrition is mild. Once malnutrition is advanced, it becomes a significant disease in itself and its effects super-vene on the psychologic picture. It needs then to be dealt with but this is only the beginning—not the end—of treatment. Ideally, treatment involves attention to both the physiologic and psychologic needs of the patient.

Principles involve:

- (1) educational discussion of the illness,
- (2) setting of realistic goals with the patient,
- (3) treatment for malnutrition,
- (4) treatment of the emotional disorder

Treatment may be administered by a general physician or psychiatrist independently or conjointly and may be planned on an outpatient basis or in a hospital depending on the severity of the illness.

DIETARY PRINCIPLES

An aspect of treatment is the approach to diet. This may involve a dietician working closely with the physician. In

mild cases with clear problems within the family dynamics, it is often best to ignore the diet altogether and focus on the psychologic aspects of treatment. Many such patients, whose illness is not far advanced, will begin eating normally once the focus of conflicts is removed from the eating arena. Other patients, however, with primary anorexia nervosa and an advanced stage of malnutrition will be unable to begin eating on their own. They can profit from diet instruction as part of the educational process. Normal nutritional needs and the importance of consistent daily intake are presented in a flexible manner. With the most severely ill, physically and psychiatrically, hospitalization will be needed to provide clear but non-coercive structure and expectations for eating associated with individualized psychotherapy.

The principles of dietary treatment involve beginning with the basal caloric requirement and adding a small increment for activity calculated to maintain weight initially. To take the example of a 15-year-old girl, 64 inches in height, weighing 80 pounds, who had weighed 110 pounds at age 14, her basal energy requirement would be 1000 calories considering a diminished basal metabolic rate of -20 percent at that stage of malnutrition. Adding 25 percent for activity would yield a total daily diet of 1250 calories, a reasonable starting point. As tolerated, the caloric content of the diet is gradually increased over some weeks until a normal level is reached. The average 15 to 16-year-old girl, who weighs 120 pounds, has a basal requirement of 1500 calories and a total requirement of approximately 2200-2600 calories, depending on the amount of activity.⁸ Thus, it can be seen that starting the patient on a "normal" teen-age diet of 2600 calories would be wrong; this amount cannot be tolerated in the starved hypometabolic state.

Water is retained initially as the patient becomes rehydrated and some edema often results. Liver and muscle glycogen is then restored and finally fat is deposited. If the physician prescribes a diet knowledgeably and if the patient follows it truthfully, there will be daily fluctuations in the weight. Following initial weight gain, there is often a plateau or drop in weight as edema fluid is lost and finally a steady, continuous rise in weight occurs.

SUMMARY

Anorexia nervosa is a disorder which has both physiologic and psychologic determinants and manifestations. A specific cause is not known nor are there reliable statistics on its prevalence. Early diagnosis is important to effective treatment. The treatment should consider both the physiologic and psychologic needs of the patient. Dietary management requires the knowledge that the body's caloric needs are diminished in the emaciated hypometabolic state.

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DOCTOR'S NOTEBOOK

Trustees Minutes

May 11, 1979

A regular meeting of the Board of Trustees was held on Friday, May 11, 1979, in Atlantic City. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

MSNJ Dues' Collection . . . Noted that as of this date (May 11, 1979) there were 7,146 dues-paying members.

Headquarters Building . . . Noted that mortgage closing with Prudential Insurance Company on the corporate headquarters at Two Princess Road, Lawrenceville, took place on May 4.

. . . Noted that bids in the amount of \$360,000 have been accepted for completion of the portion of the building to be occupied by the New Jersey State Medical Underwriters, Inc., the Academy of Medicine of New Jersey, and the New Jersey Foundation for Health Care Evaluation.

Budget Analysis . . . Received a statement of accounts as of April 30, 1979 and a budget analysis—quarterly statements of budget performance will be supplied to the Board.

Administering Medication in New Jersey Schools . . . Approved the following recommendation from the Council on Public Health as amended by the Board: (*Italics indicate Board amendment.*)

That school nurses be permitted to administer medication to *specific students upon orders of their private physician.*

International Year of the Child . . . Approved the following recommendation from the Council on Public Health which had been submitted by the Special Committee on Child Health:

That MSNJ endorse, as has the AMA, the health care initiatives during the International Year of the Child—1979. These include the December 1978 AMA House of Delegates

Resolutions that promote breast feeding, support the American Academy of Pediatrics "Speak Up for Children Program," and promote seat-belt restraints for infants and children. The Committee further recommends the full support of MSNJ and its members in attaining the goals of the International Year of the Child—1979 that focus on:

(a) **Accident Prevention**—because accidents are the greatest cause of death and suffering among American children.

(b) **Nutrition**—because good nutrition starting at conception and continuing through adulthood is basic to a healthy, productive life.

(c) **Immunization**—because children must be protected against supposedly "conquered" diseases still capable of producing epidemics.

(d) **Health Education**—because effective health education for children, adolescents, and their families can contribute to happier, healthier, and more productive lives.

Eye Health Screening Program . . . Approved the following recommendation from the Special Committee on Conservation of Vision:

That the Eye Health Screening Program be conducted in 1979 during the week of October 7, 1979.

. . . Suggested, in view of the decline in number of people screened in 1978, that MSNJ request support from organizations such as the Lions Clubs, Commission for the Blind, women's clubs, and the New Jersey Chapter for the Prevention of Blindness to publicize the program.

Mobile Intensive Care Unit . . . Approved the following recommendation from the Committee on Emergency Medical Care:

That the Special Committee on Emergency Medical Care approves the Emergency Technicians Program (Paramedics) and recommends to the Board of Trustees that state legislators be notified that the MICU program (A-1686) should be continued, not as a pilot program, but as a continuing effort utilizing the state guidelines as established by the state MICU program. In addition, it was recommended that any interested hospital that wishes to become involved and meets the criteria should do so.

Note: As a consequence of EMS Re-

gionalization Regulations having been voted down by the HSA, a mobile intensive care didactic course in Trenton was cancelled as were funds for nine pilot programs. Unless there is an extension, the MICU program will expire in June. It was hoped that MSNJ will work toward continuation of the program in conjunction with the New Jersey Hospital Association.

State Board of Medical Examiners . . . Received as informative a report from Richard E. Lang, M.D., on the May 9 meeting of the State Board of Medical Examiners which discussed the following items:

1. **Amphetamines**—There are now two appeals to the amphetamine regulation, and treatment of senile and apathetic patients has been added as a sixth diagnosis where the use of such drugs would be permitted. The State Board suggested that pharmacists bear some of the responsibility for amphetamine prescriptions as they are obligated to contact the physician by phone to verify that the prescription is for use in treatment of one of the six disorders set forth in the regulation.

2. **Excessive Fees**—The State Board recognizes that two-thirds of the physicians of the State of New Jersey are members of MSNJ and that some sort of persuasion could be exercised through the use of the Society's judicial mechanism. However, since one-third of the physicians are not members, it is necessary to address the problem of excessive fees, and regulations will be instituted.

3. **Availability of Physicians' Records**—Regulations are proposed for the notification of the availability of a physician's records at the time of his retirement or death.

Midwifery . . . Assembly Bills 3245 and 3246 relating to midwifery have been introduced. The first concerns regulation and licensing of nurse/midwives and creates a nurse/midwife examining

committee. The second prohibits the State Board of Medical Examiners from creating new licenses or renewing current licenses to practice midwifery under the present law. A member of the State Board of Medical Examiners, Joseph A. Riggs, M.D., has written to the sponsor of these bills, Assemblyman Kern, indicating why the legislation would be detrimental to women and infants and asking that the bills be rescinded. Dr. Riggs will supply a copy of the bills and the letter he submitted for use by the Council on Legislation.

Equal Coverage of Psychiatric Patients Under HMOs and IPAs . . . Agreed that the investigation by Doctors Bernstein and Morrison of alleged discrimination of psychiatric patients by IPA/HMOs should be continued, and that their recommendations be presented at the September meeting of the Board of Trustees.

Note: The investigation resulted from a request of Morton Friedman, M.D., that MSNJ not support the formation of IPA/HMOs which discriminate against patients with mental illness. An interview with the medical director of CoMed-IPA has revealed the following regarding psychiatric coverage:

(a) CoMed pays UCR fees for psychiatric visits up to 20 per year, each with a \$10 copayment.

(b) CoMed pays full hospital care for psychiatric admission in the subscribing hospitals up to a maximum of 30 days.

(c) These limits are the minimum dictated by the HMO law as reported in the *Federal Register* of October 18, 1974.

(d) Other limitations of CoMed also referred to in the same regulation are:

(1) No eye refractions after age 17 are covered.

(2) No preventive dental care after age 11 is covered.

(3) No corrective appliances and artificial aids are covered.

(4) No cosmetic surgery unless medically necessary; i.e., after trauma or illness is covered.

(5) No ambulance services unless medically necessary are covered.

(6) No annual physical examinations unless considered necessary by the primary physician (i.e., not for company or patient request).

(7) Drug or alcohol abuse except for detoxification, referral, and as necessary for treatment of medically related diseases. *Long-term therapy* is not included.

(8) No coverage for treatment of military service-connected disabilities for which member is legally entitled (if facilities available).

(9) Care required by state or local law must be treated in public facilities (types of mental diseases).

Discussion of reasons for no larger psy-

chiatric coverage—

(a) Actuarial advice, that the plan might not survive financially if unlimited coverage because of continuous nature of psychiatric care. (Data: 9 of 10 visits were repeat visits for the same diagnosis; 89% of psychiatrists' visits resulted in the instruction to return at a specified time and only 4% had no follow-up plan; Advance Data U.S. Dept. HEW #38 August 1978)

(b) With full coverage there is little incentive for the patient not to return as the visits are painless and unfearful, unlike other patient visits.

(c) There are a number of psychotherapists who feel that psychotherapy is ineffective when the patient pays nothing.

(d) There is a growing feeling among psychiatrists that Freudian analytic technique is unproductive and therefore that unlimited visits are not productive.

(e) Overlapping of state and federal mental health programs already funded.

Future Plans for Coverage

All coverages will be reviewed annually based upon:

(1) Financial status of CoMed

(2) Patient demand

(3) Physician wishes and advice

(4) Patient willingness to pay for increased coverage

At present CoMed-IPA cannot enlarge coverage until the federal loan is repaid and the plan is in the black.

CAT Scanners as a Shared Service . . .

Referred to the Bergen-Passaic Hospital and Physicians Council for discussion with the Bergen-Passaic Health Systems Agency the propriety of shared services of CAT scanners by Englewood and St. Joseph's Hospitals as a condition for receiving a certificate of need.

Statewide IPA/HMO Project . . .

Directed that communications and position statements from the Crossroads Health Plan, CoMed, Inc., the Atlantic Cape Health Services, and Southshore Health Plan objecting to the conclusions reached in the report, "A Feasibility Study of the Practicality and Ability to Develop a Single Statewide IPA/HMO in New Jersey," prepared by the New Jersey Foundation for Health Care Evaluation, be referred to the task force to oversee the implementation of a multi-service area HMO.

Anesthesiologists' Allowances . . .

Deferred action on the matter of the New Jersey State Society of Anesthesiologists' attempting to rectify, through negotiations, the economic injustices experienced by anesthesiologists with third-party payers, so as to allow more time to review communications from that society.

Scoliosis Screening Examinations . . .

Received as informative a communication from the New Jersey Orthopaedic Society regarding their concern that unqualified persons are performing scoliosis screening examinations, mandated by the State, of New Jersey school children. The Orthopaedic Society would be pleased to cooperate with any local district or State board of education committees to facilitate this screening program.

Medicaid Audit . . .

Deferred consideration and directed that copies of a letter from Vincent F.M. Catanzaro, M.D., dated April 23, 1979, and other pertinent material be supplied for study in the matter of alleged harassment of Dr. Catanzaro by the Department of Human Services, Division of Medical Assistance and Health Services, Bureau of Medical Care Surveillance in auditing procedures involving Medicaid patients.

Resolution on Continuing Medical Education . . .

Directed New Jersey's Delegates to the AMA to support the resolution received from the Medical and Chirurgical Faculty of the State of Maryland, which had been referred to MSNJ's Committee on Medical Education, and in which they were in full agreement.

Whereas, standards for accreditation of continuing medical education in Maryland were the result of an agreement between the American Medical Association and the Medical and Chirurgical Faculty of the State of Maryland in 1972; and

Whereas, the Committee on Continuing Medical Education of the Medical and Chirurgical Faculty of the State of Maryland was the recognized body delegated the responsibility of overseeing continuing medical education activities in the State of Maryland; and

Whereas, this aforementioned Committee continues to function as the only organization in Maryland delegated the authority to review institutions and organizations in order to ascertain their qualifications for accreditation for continuing medical education; and

Whereas, this same Committee gives consultation and guidance to organizations and institutions in the State who have applied for accreditation as well as those already accredited; and

Whereas, an intolerable delay in the accreditation process has occurred since this authority passed from the American Medical Association to the Liaison Committee on Continuing Medical Education (LCCME); and

Whereas, the Liaison Committee on Continuing Medical Education has drawn nationwide

criticism for failing to keep state continuing medical education committees currently well-informed; and

Whereas, many state continuing medical education committees have joined, out of frustration and/or concern, the National Council of State Committees on Continuing Medical Education; and

Whereas, the Maryland State Board of Medical Examiners does not recognize the AMA's Physician's Recognition Award as a valid instrument for the purpose of re-registration of license to practice medicine in the State of Maryland; therefore be it

Resolved, that the Medical and Chirurgial Faculty of the State of Maryland reaffirm the concept of accreditation of continuing medical education by those state medical associations whose standards for continuing medical education are in agreement with those established by the AMA and the Liaison Committee on Continuing Medical Education; and be it further

Resolved, that the Medical and Chirurgial Faculty of the State of Maryland instruct its delegates to the AMA to support the principle that the LCCME permit those state medical associations whose standards are in agreement with the AMA and the LCCME, once again to accredit institutions and organizations within their jurisdiction for continuing medical education; and be it further

Resolved, that failing such an agreement, the Medical and Chirurgial Faculty of the State of Maryland cease recognition of the LCCME as accrediting authority for continuing medical education in the State of Maryland and concern itself with the continuing medical education needs of the physicians of the State as mandated by the Maryland State Board of Medical Examiners; and be it further

Resolved, that a copy of this resolution be sent to the CME Committee of each state, district, and territory with the recommendation that they consider and support similar action in their state."

Conflicting Dates of MSNJ and Major Specialty Societies' Annual Meetings . . .

Noted that at least three communications had been received from members of the American Psychiatric Association concerning conflicting dates with that Society's and MSNJ's annual meetings. MSNJ does try not to conflict with major specialty meetings but is not always successful.

Honoraria for Guest Speakers . . .

Directed the Committee on Annual Meeting to notify each of the officers of the scientific sessions that it is customary for the scientific sessions to present a program whereby half of the speakers are from out of state (whose expenses are paid by MSNJ) and the other half are MSNJ members, and that if the

session plans to present a program which contains more than three guest speakers so to notify the Committee for clearance *in advance*.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

Although the action taken by the Board of Higher Education in April represents a compromise with the College's plan to effect a four-year program for the CMDNJ-New Jersey School of Osteopathic Medicine in South Jersey, it will establish a physical presence of CMDNJ in the area through the construction of a clinical educational facility in Camden for students of both allopathic and osteopathic medicine. We have cause for satisfaction with the Board of Higher Education's resolution of this difficult issue, for it establishes for the first time a viable presence in South Jersey for a medical school with an enrollment which all agree is cost-effective.

Coming after four months of debate on many existing positions on the development of medical education throughout the state, the action also provides for:

- An adequate facility for CMDNJ-Rutgers Medical School for the accomplishment of its dual mission of basic science education for both allopathic and osteopathic students at the school's Piscataway campus.
- A reappraisal of CMDNJ's South Jersey education program after four years to determine whether a basic science facility for the College's school of osteopathic medicine is the most appropriate course to follow.

The proposed clinical education facility in Camden, to be constructed at an estimated cost of \$8 to \$9 million will have faculty offices, classrooms, and laboratories for third and fourth-year students in the CMDNJ-New Jersey School of Osteopathic Medicine and in the College's South Jersey Medical Education Program. It will be built near the Cooper Medical Center, the core teaching hospital for allopathic students in that program, and will be under the management of the dean of the osteopathic medicine school.

In addition to the new building in Camden, facilities will be constructed at

the Piscataway campus to meet the demands of expansions of both the allopathic and osteopathic programs. As a direct result of the BHE decision, plans call for eventual enrollment of 56 osteopathic medicine students per class at Piscataway during their first two years of education, as well as 56 students per class at the new Camden facility during the final two years of study.

The BHE action directs that 382 physicians be graduated from CMDNJ each year beginning in 1983. At present, it is envisioned that the allocation of student-per-school will be: CMDNJ-New Jersey Medical School, up to 200 students per class, with distribution between Newark and South Jersey in the last two years to be determined; CMDNJ-Rutgers Medical School, 108 graduates, including 16 from the COTRANS Program; CMDNJ-New Jersey School of Osteopathic Medicine, 56 graduates; and the South Jersey allopathic educational program, 48 graduates, including 18 from COTRANS.

By 1983, it is proposed that the clinical center in Camden will be utilized by 112 students of osteopathic medicine and 96 allopathic medical students. The allopathic students will receive their clinical education at Cooper Medical Center and eventually at the proposed new Veterans Administration Hospital in Camden. Currently, 12 allopathic students are involved in that program, while 24 osteopathic students will start their clinical education this summer at the John F. Kennedy Memorial Hospital in Stratford.

While the compromise plan does not put an immediate end to the "split-campus" arrangement for osteopathic students, it does leave open the possibility of moving basic science education to Camden in 1983/84. This decision will be made on the basis of recommendation from a committee of nationally prominent medical education experts to be appointed by CMDNJ with approval by the Department of Higher Education. Elimination of the "split-campus" was one of the principal objectives in the CMDNJ proposal for a four-year osteopathic medical program in South Jersey.

All things considered, the approved plan points to a bright future for medical education and health care accessibility for the southern part of the state. We believe that the reasoning, good faith, and intelligent compromise by all the agencies involved has resulted in a design for growth in which we all can have confidence.

PSRO and IPA: A Sound Partnership for Quality Assurance in the Health Maintenance Organization*

The following report describes the product of a partnership between an Individual Practice Association, a Health Maintenance Organization, and a PSRO. This cooperative effort between three such organizations seemed, to the physicians and the administrators of the plans in Essex County, the obvious way to proceed in the development of a quality assurance program for patients and members of the HMO in the county.

The Essex Physicians' Review Organization (EPRO), was incorporated in 1974 and has been operating as a PSRO for Essex County since that time. Presently all hospitals in the county are performing reviews and quality assurance activities on patients funded by the Federal Government in accordance with policies established by the organization. Over 1,400 of the 2,000 actively practicing physicians in the area are members of EPRO and participate in our quality assurance activities.

It was the intent of the original incorporators of the PSRO that EPRO act as the quality assurance and peer review authority in the area for all third party payment programs and, while the PSRO has not aggressively pursued this private market, it always has been willing to assume the leadership role in such activities. The Corporate Chapter authorizes the corporation "To contract with Insurance Carriers or Agencies to provide peer review services under Titles XVIII, XIX, and V of the Social Security Act, and also, if it deems it advisable and not contrary to law, with other Insurance Carriers, Independent Practice Associations, or others to provide peer review services."

Through the able leadership and sponsorship of the Essex County Medical Society, the Essex County Health Organization (ECHO) was formed several years ago. This Individual Practice Association (IPA) in an HMO model had as its goal the provision of a comprehensive range of benefits to the patients of Essex County with the maintenance of the patient-physician rela-

tionship and the traditional fee-for-service concept of physician reimbursement. Not surprisingly, the IPA membership and leadership is made up of many of the same physicians who also serve as leaders in the PSRO.

As the IPA matured and the relationship with the Crossroads Health Plan, a local HMO, flourished, it became clear to the physician leadership that IPAs had significant quality assurance and utilization control obligations in order to maintain a viable, competitive position in the market and at the same time furnish quality medical care to the patients in the plan. Furthermore, the HMO Assistance Act under which the planning and development of such HMOs can be funded, requires extensive quality assurance safeguards. Since they already had developed a sound and functioning PSRO, the leadership decided that duplicating those programs and structures within the IPA would be a waste of effort and premium dollars. Therefore, the HMO and the IPA agreed to utilize the expertise and services of the PSRO to the greatest extent possible in the pursuit of quality assurance activities.

EPRO's Health Care Standards Committee, which was comprised of approximately 25 physicians representing most specialties and sub-specialties, had convened numerous times before for the development of various review criteria. Review Coordinators, who are registered nurses on the EPRO staff, worked with this committee and were familiar with the process of criteria development through earlier projects. Secretarial and other support was readily available within the PSRO administration. The IPA was a newly formed organization with neither experience in criteria development nor administrative staff. The PSRO Health Care Standards Committee was expanded to include members of the IPA within the four specialties of internal medicine, family practice, obstetrics/gynecology, and pediatrics.

The consolidation of administrative efforts on the part of the IPA with the PSRO represented a significant partnership in the area of quality assurance for Essex County physicians. This arrangement eliminated any potential administrative duplication of expense or overlap of activities insofar as the physicians were concerned. Furthermore it guaranteed an opportunity for legitimate input by practicing physician members of the IPA to the development and operation of the review process to be employed for the HMO. Essentially it insured the re-

tention of peer review for the patients and physicians of the Crossroads Health Plan.

METHODS OF PROCEDURE

As a first step Crossroads inpatients were subjected to the review and approval of their admissions and lengths of stay by physicians and reviewers performing under the auspices of the PSRO via arrangements with the delegated hospitals' Utilization Review Committees, under an operational contract between the HMO and EPRO.

In July 1977, EPRO entered into a project with IPA physicians, funded by the parent HMO, for the development of ambulatory screening criteria to be utilized in the claims' screening process for ambulatory HMO patients. Panels of specialists were established in internal medicine, family practice, obstetrics/gynecology, and pediatrics. The panels were drawn from physicians who were members of the PSRO and IPA. The panels met as a sub-committee of the EPRO Health Care Standards Committee, (chaired by one of the authors, Bernard Robins) to establish these screening criteria for a significant number of conditions most likely to be seen in the early operation of the HMO.

The sub-committee met as a whole, and more frequently by specialty panel, constantly through the autumn and winter of 1977. Their first task was to identify and obtain copies of as many creditable ambulatory screening criteria as possible. Once this reference library was assembled and reviewed, the sub-committee agreed upon a format for the presentation of the criteria. With the knowledge that initial claim screening for quality and utilization would be done manually and the number of claims would be small, it was decided to develop explicit and unambiguous guidelines so that non-physicians could do the reviews. Further, it was necessary that the guidelines cover at least 75 percent of the conditions for which claims would be submitted in the first year or so.

Finally, we decided that the criteria would be reviewed constantly, modified, and added to as necessary. A list of approximately 100 diagnoses or conditions representative of the most frequent causes for physician visit was developed. The panels then set about the task of developing criteria for each.

In November 1977, the Health Care Standards Committee presented the draft manual to the EPRO Board for review and approval, and then to the

*Prepared by Bernard Robins, M.D., President and Arthur Bernstein, M.D., Medical Director, Essex County Health Organization (ECHO), and by B. Marc Allen, J.D., Executive Director, Essex Physicians' Review Organization (EPRO).

IPA Peer Review and Quality Assurance Committee and the Medical Director. Finally, in the spring of 1978, copies of a completed set of guidelines were distributed to the HMO and IPA for use in the claims' screening process where they are now in daily active use.**

THE PROCESS

Upon receipt of a claims form from a physician, a claims supervisor in the finance department of the HMO screens the claims for eligibility of the patient, for completeness and accuracy of data, and for financial guidelines. When approved, the claim is forwarded to the Manager of Health Services Coordination, a registered nurse, who screens the claim against the model treatment guidelines described above. If the claim meets the criteria required in the guidelines, it can be approved for payment. If not, the record is sent to the IPA's Medical Director, who may seek further information from the physician by telephone or in writing, before a decision to approve or disapprove the claim is made. All such claims which are disapproved by the Medical Director are sent to the Peer Review Committee for review and final decision. To familiarize himself with the procedures, the Medical Director looks at a large portion of all claims in order to identify deficiencies in the criteria or the process.

The EPRO sub-committee on Ambulatory Model Treatment Guidelines will reconvene in the near future to assess the criteria for revisions and expansion, but at this point it feels that the project to date has been successful.

CONCLUSION

We believe this partnership is somewhat unique in the annals of IPA and PSRO development, but that it is a logical approach to utilize existing resources of their own PSRO for the development and performance of certain quality assurance activities.

These are process oriented rather than outcome criteria and represent minimal standards. The "peer" aspects of the project indicate the emphasis on quality of care rather than strict utilization as was historically the case in insurance company claims review. We believe that the PSRO has a well trained staff in these areas and can provide such assistance to the IPA and thus minimize the administrative work load and costs for IPA physicians. It was very difficult to convince federal representatives that this was an appropriate method for the development of an ambulatory screening

system, but at this point it is an approach that has been well accepted, both by the physicians and their federal colleagues, and should stand as a model.

If You Examine Eyes . . .†

. . . you are concerned with the activities of the New Jersey State Commission for the Blind and Visually Impaired. Legally, blindness is defined as vision of 20/200 or less in the better eye with best correction, or a peripheral field of vision restricted to 20° or less. Patients who are blind by legal definition must be referred to the Commission in accordance with the statutes of New Jersey.

The following services are available:
Education—Instruction in braille, typewriting, and various communications skills are provided to help prepare young blind individuals for college or a vocational future. Testing is offered for the proper assessment of the student's intellect, interest, and aptitude. There is diverse counseling, and a summer camp recreational program.

Home Services—Instruction is provided in various crafts, both for leisure time interest and supplemental income. Instructions in braille, typewriting, cooking, and the activities of daily living also are available. Expert counseling is also offered to the newly blind individual in this most crucial period of his life.

Vocational Rehabilitation—Services are available to train and place capable blind persons in gainful employment. Instructors teach the newly blind individual skills in independent travel. Prior skills and experience are utilized to rehabilitate the blind person successfully to take his place in a job and in meaningful community life. Visitors are invited to observe the diagnostic and job-training program at the Commission's Vocational Rehabilitation Center in Newark.

Eye Health Services—This department arranges:

- 1. Eye examination and treatments.
- 2. Hospital eye care.
- 3. Preschool vision screening for the detection of amblyopia, with early referral for treatment.
- 4. Eye screening to detect glaucoma and other diseases.
- 5. Eye surgery for eligible clients within the scale of Blue Shield payments.
- 6. Mobile Eye Health Unit to provide ophthalmological examinations for vulnerable groups—including the handi-

capped; the institutionalized, migrant laborers, and needy elderly people.

- 7. Low Vision Program—consultation for those in need of low vision visual aids.
- 8. Diabetic Retinopathy Unit—services to eligible clients for periodic fundus photography, fluorescein angiography, and laser photocoagulation.
- 9. Public education and information on blindness, services of the New Jersey Commission for the Blind and Visually Impaired, and prevention of blindness.

All the above services can be afforded by the blind person only if you, as ophthalmologists, have regard for your obligations as physicians and citizens in referring patients to the Commission promptly. The completion of the eye report forms as thoroughly as possible is of utmost importance to the patient. For information and forms contact the Commission at 1100 Raymond Boulevard, Newark, New Jersey 07102.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Once again, the House of Delegates of MSNJ has endorsed continued funding of your Foundation. We are gratified at the support of the membership for our activities. The House and the membership had several presentations on the influences of government and other forces on medical practice, and the need for physician awareness. The Foundation has been calling attention to these trends since its inception. Our seminar on Medical Care in the 1980s presented provocative discussions. The presentation by the Orthopaedic and the Family Practice Sections was devoted to political and socioeconomic factors, and was very stimulating. Dr. Robert Hunter, Chairman of the AMA Board of Trustees, issued a challenge to physicians to be informed and responsive. Some of the topics are unpleasant to hear, and they divert some attention from the scientific presentations, but they are important. We congratulate Dr. Charles Krueger on his excellent term as MSNJ President, and extend our best wishes to Dr. Alfred Alessi, who is now at the helm.

**Readers may obtain copies from the authors.

†Prepared by Humbert M. Gambacorta, M.D., Medical Administrative Consultant, New Jersey State Commission for the Blind.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Douglas C. Wiseman, D.O., TH264 Pine Run, Blackwood 08012. College of Osteopathic Medicine, Kansas City (1974). Also general internal medicine. Board eligible (IM). Solo, group, partnership. Available.

Richard W. Huss, M.D., 555 Graham Rd., Fort Sam Houston, TX 78234. CMDNJ 1973. Subspecialty, immunology. Board certified. Group, partnership, solo. Available October 1979.

ANESTHESIOLOGY—June Hyung Rim, M.D., 11 Park Avenue, Apt. 3-0, Mt. Vernon, NY 10550. Seoul (Korea) 1973. Board eligible. Partnership, solo, group. Available.

Andrew Chih-Kang Cheng, M.D., 435 East 70th Street, Apt. 22-F, New York, NY 10021. Peking (China) 1962. Board eligible. Group, partnership, solo, administrative, research, or academic. Available.

Romeo Yangco Sembrano, M.B., Herbert J. Thomas Memorial Hospital, South Charleston, WV 25309. Santo Tomas (Philippines) 1962. Also general family practice. Board eligible. Solo, emergency room, partnership. Available.

Barry M. Baylis, M.D., 2130 Williamsbridge Road, Bronx, NY 10461. Wisconsin 1971. Board eligible. Partnership, group, solo. Available.

Raveendra Vithal Limaye, M.D., 335-D Third Avenue, Long Branch 07740. Baroda (India) 1972. Board eligible. Partnership, single or multispecialty group, institutional. Available September 1979.

Tulsiram Gowlikar, M.D., 2951 S. King Drive, Apt. 1009, Chicago, IL 60616. Gandhi (India) 1972. Board eligible. Solo, partnership, single-specialty group. Available.

Kiritkumar Sheth, M.D., 2851 S. King Drive, Apt. 1117, Chicago, IL 60616. Baroda (India) 1972. Special interest, family practice. Board eligible. Partnership, solo, public health. Available.

CARDIOVASCULAR DISEASES—Bulent Dincer, M.D., 270 Henderson St., Apt. 6-F, Jersey City 07302. Hacettepe University, Ankara (Turkey) 1972. Also general internal medicine. Board eligible (IM). Research, academic, or multi-specialty group. Available.

Chi-Kwong Iai, M.D., Deborah Heart & Lung Center, Browns Mills 08015. National Defense Medical Center (Taiwan) 1972. Also general internal medicine. Board certified (IM). Single or multi-specialty, group, institutional. Available.

Mylapanahalli Sanathanamurthy, M.D., 905 Pine Avenue, Apt. 13, Redlands, CA 92373. Bangalore (India) 1971. Also gener-

al internal medicine. Board eligible (IM). Multi- or single specialty group, institutional. Available.

Bhagwan Dass Gupta, M.D., 4671 Dalebridge Road, Apt. 412, Warrensville Heights, OH 44128. All India Institute of Medical Science 1973. Also general internal medicine. Single or multi-specialty group, solo. Available.

Roger Neiss Zitrin, M.D., Micieli Place, Brooklyn, NY 11218. Rutgers, 1974. Also general internal medicine. Board eligible (IM). Solo, single or multi-specialty group. Available September 1979.

David H. White, M.D., 4119 Flint Hill, San Antonio, TX 78230. University of Texas 1972. Also general internal medicine. Board certified (IM). Institutional, single or multi-specialty group, partnership. Available.

Soma Narshiah Pulipati, M.D., 725 East Main Street, Kings Park, NY 11754. Osmania (India) 1971. Also general internal medicine. Board certified (IM). Solo, partnership, group. Available.

Vijay G. Mistry, M.D., 203 Fair Hill Towers, 12000 Fair Hill Road, Cleveland, OH 44120. T.N. Medical (India) 1973. Also general internal medicine. Board eligible (IM). Single or multi-specialty group, partnership. Available.

Sabba Rao Chennupati, M.D. 407 Lindsay Court #12, Louisville, KY 40206. Rangaraya (India) 1970. Board eligible. Group, partnership, solo. Available July 1979.

Narayanaiyengar R. Devaraj, M.D., 2851 S. King Drive, Apt. 814, Chicago, IL 60616. Mysore (India) 1973. Also general internal medicine. Board certified (IM). Board eligible. Institutional, single or multi-specialty group. Available.

Naresh K. Pruthi, M.D., 2600 44th Avenue, Apt. 1, San Francisco, CA 94116. All India Medical Institute 1973. Also general internal medicine. Board certified (IM). Solo, partnership, group. Available.

Nagorao V. Karhade, M.D., 1926 W. Harrison Street, Apt. 1804, Chicago, IL 60612. Aurangabad (India) 1970. Also general internal medicine. Board certified (IM). Board eligible. Solo, partnership, group. Available.

Dhirendra Mohan, M.D., 757 Main Street, Apt. 30, South Portland, ME 04106. King George (India) 1968. Also general internal medicine. Board certified (IM). Board eligible. Solo, industrial, emergency room. Available.

Brojesh C. Pakrashi, M.D. Medical Center, Morgantown, WV 26506. Medical College of Calcutta (India) 1958. Also general internal medicine. Board eligible (IM). Research, academic, institutional. Available.

DERMATOLOGY—Sam Stieglitz, M.D., 26151 Lakeshore Blvd., Apt. 2115, Euclid, OH 44132. McGill (Canada) 1971. Also general internal medicine. Board certified (IM). Solo, partnership, single specialty group. Available.

David R. Benjamin, M.D., 2911 Stonecliffe Drive, Pittsburgh, PA 15146. Pittsburgh 1974. Also general internal medicine. Board certified (IM). Multi-specialty group, solo, partnership. Available.

EMERGENCY MEDICINE—Jose S. Encanto, M.D., 89-06 135th Street, Apt. 7-J, Richmond Hill, NY 11418. Santo Tomas (Philippines) 1971. Special interest, clinical pathology. Board eligible (CP). Emergency room, institutional, multi-specialty group. Available.

ENDOCRINOLOGY—George Tun-Yang M.D., 1764 Bising Avenue, #2, Cincinnati, OH 45239. Taipei Medical (Taiwan) 1972. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1979.

Ranjan P. Shah, M.D., 6120 Bellaire Boulevard, Apt. 812, Houston, TX 77081. University of Bombay (India) 1968. Also general internal medicine. Board eligible (IM). Any type practice. Available.

Subramanyam K. Naidu, M.D., 1408-F Druid Valley Drive, Atlanta, GA 30329. S.V. University (India) 1971. Also general internal medicine. Board eligible (IM). Solo, institutional, partnership. Available.

Bruce J. Shickmanter, M.D., 401 East 88th Street, Apt. 11-E, New York, NY 10028. Upstate Medical Center (NY) 1974. Also general internal medicine. Board certified (IM). Board eligible. Single or multi-specialty group, partnership. Available August 1979.

FAMILY PRACTICE—John Schifferdecker, M.D., 52-08 69th Street, Maspeth, NY 11378. Mount Sinai, New York 1976. Board eligible. Partnership, single or multi-specialty group. Available July.

Mark J. Decker, M.D., 115 Newbrook Lane, Bay Shore, NY 11706. Georgetown 1975. Board certified. Single specialty group, partnership, solo. Available.

Kirit D. Trivedi, M.D., 546 West Ridgeway Street, Warrenton, NC 27589. Baroda (India) 1965. Special interest, emergency medicine. Board certified (general surgery). Single specialty group, solo, partnership. Available.

Chik S. Chin, M.D., 21 Walnut Road, Apt. 1-1A, Glen Cove, NY 11542. Taiwan 1974. Board eligible. Single or multi-specialty group, institutional, partnership, solo, emergency room, school health. Available.

Romeo Y. Sembrano, M.D., Herbert J. Thomas Memorial Hospital, South Charleston, WV 25309. Santo Tomas (Philippines) 1962. Special interest, anesthesiology. Board eligible. Solo, emergency room, partnership. Available.

Mark H. Krotowski, M.D., 7-29 Hegeman Avenue, Apt. 3-H, Brooklyn, NY 11212. Tel Aviv (Israel) 1976. Board eligible. Partnership, single or multi-specialty group. Available.

Padmini Thakkar, M.D., 1055 Mayfield Lane, Hoffman Estates, IL 60195. J.N. Medical School (India) 1975. Board eligible. Partnership, solo, institutional. Available.

Gudimetla V.S. Reddy, M.D., 6 Locust Court, Hollidaysburg Manor Apts., Hollidaysburg, PA 16648. Andhra Medical (India) 1973. Board eligible. Single or multi-specialty group, institutional. Available.

GASTROENTEROLOGY—Eva I. Vidins, M.D., 237 Highland Avenue, Warwick, RI 02886. Toronto 1966. Also general internal

medicine. Board certified (GP). Board eligible. Single or multi-specialty group, solo. Available.

Steven J. Nussbaum, M.D., 891 Clopper Road, Apt. B-1, Gaithersburg, MD 20760. SUNY-Downstate 1974. Also general internal medicine. Board certified (IM). Board eligible. Single or multi-specialty group, partnership. Available.

Mark T. Birns, M.D., 6630 SW Capitol Highway, Apt. 4, Portland, OR 97219. Einstein 1974. Also general internal medicine. Board certified (IM). Research, institutional, emergency room. Available September 1979.

Miguel A. Sarriera, M.D., Hospital Regional de Bayamon, Avenue Laurel Santa Juanita, Bayamon, PR 00619. Barcelona (Spain) 1960. Also general internal medicine. Board eligible (IM). Institutional, research, emergency room. Available.

Ira M. Litzenblatt, M.D., 4B Staunton Court Road, Farmington, CT 06032. Michigan 1975. Subspecialty, internal medicine. Board certified (IM). Group, partnership, associate. Available July 1980.

GENERAL PRACTICE—Babulal B. Dudani, M.D., 1716 Bath Road, Apt. G-8, Bristol, PA 19007. Baroda (India) 1967. Emergency room, partnership, multi-specialty group. Available.

Khun Y. Son, M.D., 2649 Arlington Drive, Apt. 202, Alexandria, VA 22306. Catholic Medical School (Korea) 1972. Solo, multi-specialty group, partnership. Available August 1979.

Sam W. Law, M.D., 60 Eldridge Street, Apt. 6, New York, NY 10002. National University (Taiwan) 1970. Group, partnership, solo. Available.

HEMATOLOGY—Janaki Giri, M.D., 357 Morris Street, Apt. 15, Albany, NY 12208. Jipmer (India) 1964. Also general internal medicine. Board eligible. Institutional, single or multi-specialty group. Available.

Charles A. Masor, M.D., 3 Mountain Way South, West Orange 07052. NYU 1974. Also general internal medicine. Board eligible (IM). Partnership, single or multi-specialty group. Available.

INFECTIOUS DISEASES—Nirmal K. Fernando, M.D., Lionel Village, Apt. P-5, North Brunswick 08902. University of Ceylon (Sri Lanka) 1970. Also general internal medicine. Board certified (IM). Multi-specialty group, institutional, partnership. Available.

INTERNAL MEDICINE—Peter Y. Lee, M.D., 319 East 24th Street, Apt. 21-D, New York, NY 10010. NYU 1974. Subspecialty, pulmonary diseases. Board certified. Single or multi-specialty group, partnership. Available.

T.S. Dharmarajan, M.D., 3990 Bronx Boulevard, Apt. 3-M, Bronx, NY 10466. Trivandrum (India) 1967. Subspecialty, nephrology. Board certified. Partnership, multi-specialty group, solo. Available August 1979.

Daniel C. Monahan, M.D., 28-4A Mt. Pleasant Village, Morris Plains 07950. CMDNJ 1976. Board eligible. Partnership, single or multi-specialty group. Available.

Pulivarti Bapurao, M.D., 199 F Howard Drive, Bergenfield 07621. Guntur (India) 1971. Subspecialty, nephrology. Board eligible. Solo, partnership, multi-specialty group. Available.

Vijayalakshmi Chamakura, M.D., St. Peter's Medical Center, New Brunswick 08903. Guntur (India) 1971. Board eligible. Institutional, public health, industrial. Available.

Madhavan R. Sasikumar, M.D., 125 Schroeders Avenue, Apt. 11-B, Brooklyn, NY 11239. Trivandrum (India) 1967. Institutional, multi-specialty group, emergency room. Available.

Stephen A. Atlas, M.D., 159 Hawthorne Avenue, Apt. 262, Central Islip, NY 11722. Wisconsin 1976. Board eligible. Partnership, multi-specialty group, institutional. Available.

Sambandam Baskaran, M.D., 2 Korado Court, Apt. 3-A Baltimore, MD 21207. Stanley (India) 1970. Board eligible. Partnership, multi-specialty group, institutional. Available.

Joo-Sock Yang, M.D., 7-15 162nd Street, Apt. 3-A, Whitestone, NY 11357. Seoul (Korea) 1971. Board eligible. Institutional, partnership, solo. Available.

Taha Hamoui, M.D., 9831 Timberwood Circle, Louisville, KY 40223. Damascus (Syria) 1972. Subspecialty, nephrology. Board certified. Any type practice. Available.

D. William Klasco, M.D., 30 Waterside Plaza, New York, NY 10010. Downstate 1974. Subspecialty, neurology. Board eligible. Industrial, emergency room, institutional. Available.

Ravindra K. Goyal, M.D., 78-40 164th Street, Apt. 4-D, Flushing, NY 11366. S.M.S. Medical College (India) 1972. Subspecialty, pulmonary diseases. Board eligible. Institutional, solo, multi-specialty group. Available.

Jose M. Amparo, M.D., R.D. 4, Thompson Road, Webster, MA 01570. Far Eastern (Philippines) 1967. Special interest, family medicine. Board eligible. Solo, partnership, emergency room. Available.

Ashok K. Shetty, M.D., 552 Amberson Plaza, Pittsburgh, PA 15213. Government Medical College (Mysore, India) 1970. Board eligible. Solo, partnership, single-specialty group. Available October 1979.

Mahmoodul H. Yekta, M.D., 227 Wintombury Ave., Apt. #4, Bloomfield, CT 06002. Darbhanga (India) 1964. Subspecialty, pulmonary diseases. Board eligible. Multi-specialty group, solo, institutional. Available.

Abziz H. Junagadhwal, M.D., 9 Nixon Court, Apt. 3-J, Brooklyn, NY 11223. Grant Medical (India) 1969. Subspecialty, pulmonary diseases. Board eligible. Partnership, single or multi-specialty group, solo, institutional. Available.

Bahoobal Kumar, M.D., 1125 Schroeders Avenue, Apt. 7-G, Brooklyn, NY 11239. Gandhi Medical (India) 1961. Subspecialty, cardiovascular diseases. Board eligible. Multi-specialty group, institutional, partnership. Available.

Jaffer J. Khan, M.D., 638 22nd Street West, Bayonne. King Edward (Pakistan) 1969. Subspecialty, gastroenterology.

Board eligible. Solo, multi-specialty group, single specialty group. Available.

Mohammad S. Anwar, M.D., 194-01A 64th Circle, Apt. 1-C, Fresh Meadows, NY 11365. Liaquat Medical College (Pakistan) 1968. Board eligible. Solo, multi-specialty group, institutional. Available.

Franciska G. Katona, M.D., Village Lane, Apt. Oak 2, Abington, PA 19001. Temple 1976. Special interest, occupational medicine. Board eligible. Industrial, academic, administrative. Available.

Anthony E. Niescier, D.O., 3106 Aspen Circle, Norristown, PA 19401. Phila. College of Osteopathic Medicine 1975. Special interest, family medicine. Single-specialty group, partnership, multi-specialty group. Available.

Chimanlal J. Patel, M.D., 89-06 135th Street, Apt. 6-A, Jamaica, NY 11418. Dr. V.M. Medical (India) 1971. Special interest, general medicine. Board eligible. Single or multi-specialty group, institutional. Available.

Devi P. Misra, M.D., 7K University Terrace, Columbia, MO 65201. S.C.B. Medical School (India) 1969. Subspecialty, pulmonary disease. Board certified. Solo, multi-specialty group, institutional. Available September 1979.

Silvestra Almirol, M.D., 234 Mass Avenue, Valley Cottage, Bronx, NY 10989. University of the East (Philippines) 1968. Subspecialty, neurology. Board eligible. Solo, multi-specialty group, institutional. Available.

Ravi K. Malpam, M.D., 1165 Rt. 22, Apt. 22, North Plainfield 07061. Osmania (India) 1972. Subspecialty, pulmonary diseases. Board eligible. Institutional, solo, or multi-specialty group. Available.

Pedro A. Rodriguez-Paiva, M.D., 2160 Matthews Ave., Apt. 6-M, Bronx, NY 10462. San Marcos (Peru) 1971. Board eligible. Single or multi-specialty group, institutional. Available.

Mayank Y. Doshi, M.D., 520 Desplaines Ave., Apt. 303, Forest Park, IL 60130. Seth G.S. Medical (India) 1970. Subspecialty, endocrinology. Board certified. Partnership, single or multi-specialty group. Available.

Muhammad G. R. Shaikh, M.D., 190-06A 69th Avenue, Flushing, NY 11365. Dacca (East Pakistan) 1964. Board eligible. Solo, partnership, single-specialty group. Available.

Muhammad Tayyab, M.D., 2112 Starling Ave., Apt. 4-L, Bronx, NY 10462. King Edward (Pakistan) 1972. Board eligible. Solo, institutional, multi-specialty group. Available.

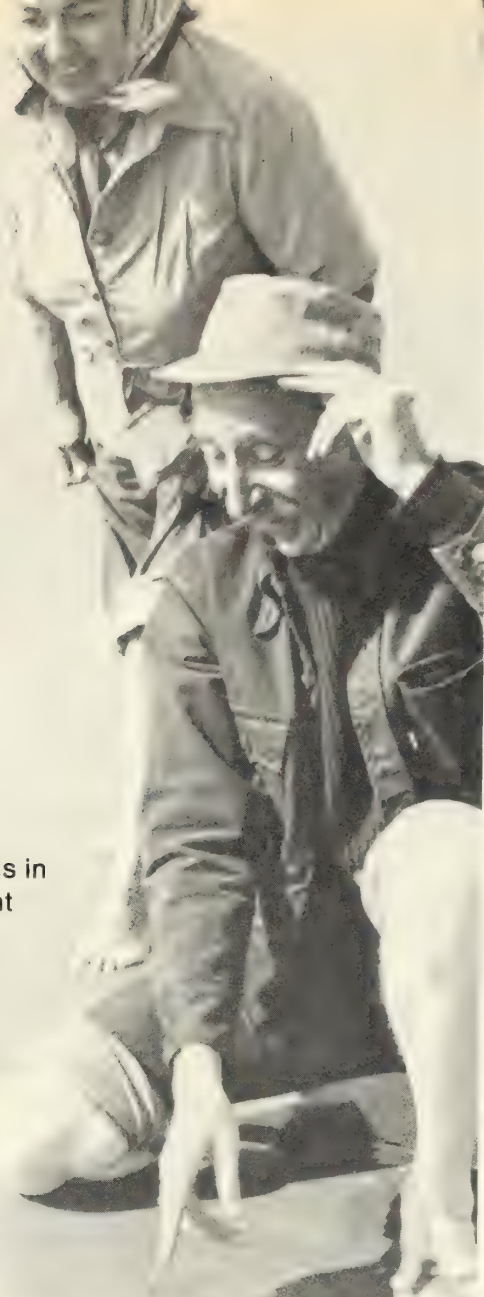
Josef H. Hertz, M.D., 840 E. 8th St., Brooklyn, NY 11230. Univ. of Bologna (Italy) 1974. Board eligible. Any type of practice. Available September 1979.

Chi-Pui Cheung, M.D., 2974 20 Lane, Apt. 3G, Brooklyn, NY 11214. National Med. (Taiwan) 1969. Subspecialties, hematology, oncology. Board certified. Solo. Available.

Soma N. Palipati, M.D., 725 East Main Street, Kings Park, NY 11754. Osmania (India) 1971. Subspecialty, cardiology. Board certified. Solo, group, partnership (in that order). Available July 1979.

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Avenue, Apt. 3-M, Bldg. 1, Norwalk, CT 06850. College of Osteopathic Medicine & Surgery 1976. Group or partnership. Available August 1980.

Charles F. McNally, M.D., Box 1774, 61 Moulton Road, Duxbury, Massachusetts 02332. New York Medical College 1968. Board certified. Solo, group or partnership. Available July 1979.

Carol D. Silver, M.D., 1619 Third Avenue, Apt. 4-G, New York, NY 10028. Duke 1970. Subspecialty, medical oncology. Board certified. Solo, group, or partnership. Available August 1979.

Kamran Hassidim, M.D., 4303 Caminito Del Zafiro, San Diego, CA 92121. Tehran (Iran) 1971. Subspecialties, hematology, oncology. Board eligible. Any type practice. Available.

NEOPLASTIC DISEASES—Victor D. Ribeiro, M.D., 82 Beacon Hill, Apt. 1B3, Dobbs Ferry, NY 10522. Goa Medical College (India) 1970. Also general internal medicine. Board certified (IM). Group or institutional. Available July 1979.

Gregory P. Burke, M.D., 45 Viscount Road, Longmeadow, MA 01106. SUNY—Downstate 1972. Also general internal medicine. Board Certified (IM). Group or academic. Available.

NEPHROLOGY—Bassam M. Haddad, M.D. 725 Scotland Road, Orange 07050. Damascus, (Syria) 1972. Also general internal medicine. Board eligible. Single or multi-specialty group, solo. Available.

Rafael A. Javier, M.D., 1350 West Bethune, Apt. 1603, Detroit, MI 48202. Univ. of the Philippines 1972. Also general internal medicine. Board certified (IM). Single specialty group, partnership, solo. Available.

Jeewanandhan Rajaratnam, M.D., 1227 South Harlem Avenue, Apt. 306, Berwyn, IL 60402. Madurai (India) 1973. Also general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available.

NEUROLOGY—Hungu Papanna Eswara, M.D., 843 School Lane House, 5450 Wissahickon Avenue, Philadelphia, PS 19155. Government Med. College (S. India) 1971. Board eligible. Solo, group, partnership, Available July 1979.

Shashi A. Husain, M.D., 325 North 15th Street, Apt. 1012, Philadelphia, PA 19102. All India Institute 1968. Board eligible. Single or multi-specialty group, research, partnership. Available.

Gerald P. Durkan, M.D., 5852 Phillips Avenue, Pittsburgh, PA 15217. Jefferson 1975. Subspecialty, emergency medicine. Board eligible. Single or multi-specialty group, partnership. Available July 1980.

Leroy J. Pelicci, M.D., P.O. Box 1357, Hershey, PA 17033. Pennsylvania State Univ. 1975. Special interest, psychiatry. Partnership, single or multi-specialty group. Available July 1980.

Peter Greco, M.D., 2100 Foxhall Rd., Washington, D.C. 20007. Georgetown 1976. Board eligible. Group or partnership. Available July 1980.

NUCLEAR MEDICINE—David B. Plone, D.O., 533 Northlake Boulevard, North

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Palm Beach, FL 33408. Phila. Coll. of Osteopathy 1968. Subspecialty, radiology. Board certified. Single specialty group, partnership, institutional. Available July 1980.

OBSTETRICS/GYNECOLOGY—Jeng Y. Lin, M.D., 945 Harvest Lane, Indiana, PA 15701. China Medical College (Taiwan) 1968. Also general practice. Board eligible. Multi-specialty group, solo, or school health. Available.

Hooshang A. Amiri, M.D., 1100 Carson Drive, Huntingtown, MD 20639. Isfahan (Iran) 1965. Board certified. Solo. Available.

Jerome B. Goldstein, M.D., 6675 E. Heritage Place South Englewood, CO 80111. Texas 1976. Any type practice. Available July 1980.

Promila Mathur, M.D., 15 First Street, Apt. 8-D, Hackensack 07601. S.N. Medical (India) 1965. Board eligible. Institutional, single or multi-specialty group. Available.

Raymond Y. Fares, M.D., 1016 Lexington Avenue, New York, NY 10021. Alexandria (Egypt) 1962. Subspecialty, pathology. Board eligible. Any type practice. Available.

Chau-Kuang Lin, M.D., Route 224 R.D., Montour Falls, NY 14865. Kaohsiung (Taiwan) 1967. Board eligible. Single-specialty group, partnership, solo. Available.

Heinz O. Osterholzer, M.D., PSC 451, K.I. Sawyer AFB, Michigan 49843. Hahnemann 1968. Board eligible. Group or partnership. Available June 1980.

ONCOLOGY—Ravi C. Khanna, M.D., 4962 Willoway Court East, Columbus, OH 43220. Amritsar (India) 1971. Also general internal medicine. Board certified (IM). Single-specialty group, partnership, solo. Available.

Pradeep S. Mahal, M.D., 12415 Newbrook Drive, Houston, TX 77072. All India 1974. Also general internal medicine. Board certified (IM). Solo, multi-specialty group, research. Available July 1980.

Enrico C. Sobong, M.D., 130 Gale Boulevard, Apt. 102, Melvindale, MI 48122. Also general internal medicine. Board certified (IM). Solo, partnership, single or multi-specialty group, institutional. Available.

OPHTHALMOLOGY—Cary H. Freeman, M.D., 2309 West Broadway, Apt. 315, Columbia, MO 65201. Howard University 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Kennth H. Zaslow, M.D., 20 Dykeman Road, Delmar, NY 12054. Albany 1973. Board certified. Single or multi-specialty group, partnership. Available.

Alan D. Gordon, M.D., 3230 Hayden Street, Sayre, PA 18840. CMDNJ 1974. Multi-specialty group, partnership, solo. Available July 1980.

Sam Katzur, M.D., 258 Middle Neck Road, Great Neck, NY 11021. University of Bologna (Italy) 1973. Board eligible. Solo, partnership, multi-specialty group. Available July 1979.

Donald S. Gerber, M.D., 510 Second Avenue, Apt. 11-F, New York, NY 10016. Stanford 1975. Board eligible. Partnership, single-specialty group, solo. Available.

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OTOLARYNGOLOGY—Vijay Chandra Singh Bais, M.D., 2174 Green Spring Drive, Kettering, OH 45440. Mahatma Gandhi (India) 1961. Board certified. Solo, partnership, group. Available.

OTORHINOLARYNGOLOGY—Sultan F. Khan, M.D., 7 Seward Street, Dansville, NY 14437. King Edward (Pakistan) 1969. Board certified. Solo, partnership. Available October 1979.

Steven R. Chesnick, M.D., 50 Wyman St., Newton, MA 02168. Pittsburgh 1974. Board eligible. Single specialty group, partnership, multiple specialty group. Available.

Jang-Huei Jang, M.D., 7563 Drumheller Dr., Richmond, VA 23225. Chung-Shan Med Col (Taiwan) 1967. Board eligible. Solo, multiple specialty group, single specialty group. Available.

PATHOLOGY—Dhanasaran Mongkolsmai, M.D., 900 West Spencer Street, Apt. 302, Philadelphia, PA 19141. Ramathibodi (Thailand) 1971. Special interest, clinical pathology. Board certified. Group, partnership, institutional. Available September 1979.

Ahm Abdul Mannan, M.D., 215 East 77th Street, Apt. 3-C, New York, NY 10021 Dacca (Pakistan) 1961. Special interest, clinical pathology. Board eligible. Group, research, institutional. Available July 1979.

A.H. Rao, M.D., 83-30 Vietor Ave., Apt. 201, Elmhurst, NY 11373. Gandhi (India) 1973. Board eligible. Partnership, institution, single specialty group. Available.

Marc G. Yagore, III, 6140 Edsall Rd., Alexandria, VA 22304. Univ. of Philippines 1972. Board certified. Institution, multi-specialty group, research, academic, administrative. Available.

Irwin J. Hollander, M.D., 2735 E. Country Club Rd., Philadelphia, PA 19131. Jefferson 1972. Board eligible. Institution, research, single specialty. Available.

Juan A. Suriel, M.D., 6 Dalecrest Court, Timonium, MD 21093. Univ. Santo Domingo 1971. Board eligible. Single or multi-specialty group, partnership, public health, research. Available.

Kong L. Tan, M.D., 338 High St., Perth Amboy, NJ 08861. Malang 1970. Board eligible. Partnership, institutional, multi-specialty group. Available.

Jose S. Encanto, M.D., 89-06 135th St., Richmond Hill, NY 11418. Univ. Santo Tomas (Philippines) 1971. Board eligible. Institution, multi-specialty group. Available.

V. A. Kagali, M.D., 54 Denby Acres, 7426 Henry Clay, Liverpool, NY 13088. Bangalore (India) 1971. Board certified. Multi-specialty group, partnership, institution. Available.

Punita P. Kothari, MD.D., 5990 Henry Avenue, Apt. 4, Philadelphia, PA 19128. M. P. Shah (India) 1969. Board eligible. Associate, group, partnership, institution. Available July 1979.

PEDIATRICS—S. R. Nanvati, M.D., 1945 Corlies Ave., Neptune, NJ 07753. B J Medical (India) 1970. Board eligible. Single specialty group, institution, solo. Available.

A. A. Vora, M.D., 63-43 Austin St., #1A, New York City 11374. All India University (India) 1962. Board eligible. Partnership, multi-specialty group, single specialty group, emergency room. Available.

Bernard Samtoy, M.D., 4634-B West Montague Ave., Charleston Hts., SC 29405. Montpellier (France) 1973. Board eligible. Single specialty group, partnership. Available August 1979.

R. K. Osei, M.D., 4000 Wilder Ave., Bronx, NY 10466. Ghana Med (Ghana) 1972. Institution, emergency room, single or multi-specialty group. Available.

R. B. Vasa, M.D., 321 East 13th St., New York City 10003. Baroda Faculty of Med (India) 1968. Board certified. Single specialty group, institution partnership. Available.

Yoon-Taek Chun, M.D., 1401 E. Hyde Park Blvd, Chicago 60615. Yonsei Univ (Korea) 1972. Board eligible. Single or multi-specialty group, partnership, solo. Available.

T. G. Thanjan, M.D., 3103 Fairfield Ave., Apt. 9K, New York City 10463. Med Col Kerala (India) 1973. Board eligible. Partnership, single or multi-specialty group. Available August 1979.

Kusum Kumar, M.D., 125 Schroeder's Ave., Brooklyn, NY 11239. Gandhi Medical (India) 1962. Board eligible. Institution, multi-specialty group, partnership. Available.

D. J. Karnik, M.D., 26 Koster Blvd., Edison, NJ 08817. Grant Med (India) 1971. Board eligible. Partnership, single or multi-specialty group. Available.

N. R. Thotakura, M.D., 10 Overlook Rd., Apt. 6B, Summit, NJ 07901. Rangaraya Med (India) 1973. Board eligible. Multi-specialty group, single specialty group, partnership. Available.

B. W. Lee, M.D., 1160 Midland Ave., Apt. 8M, Bronxville, NY 10708. Yonsei Univ (Korea) 1973. Institution, single specialty group, partnership, multi-specialty, emergency room. Available.

S. A. Bharani, M.D., 21438 Dequindre St., Apt. 101, Warren, MI 48091. Baroda (India) 1976. Partnership, public health, solo, emergency room, single-specialty group. Available July 1980.

Eugene M. Shatz, M.D., Frankfurt Military Complex, Box 55, APO, NY 09710. Temple 1971. Board certified. Single or multi-specialty group, school health. Available July 1980.

Elias G. Gouel, M.D., 6036 East Pratt, Baltimore, MD 21224. Ain Shams University (Egypt) 1971. Board eligible Group, partnership. Available August 1979.

Boo Woong Lee, M.D., 1160 Midland Avenue, Apt. 8-M, Bronxville, NY 10708. Yonsei (Korea) 1973. Board eligible. Group, partnership, solo, institution. Available.

Roy Gomez, M.D., 300 Lookout Avenue, Apt. D—9, Hackensack 07601. Trivandrum (India) 1971. Board eligible. Group, partnership, institution, solo. Available.

L. N. Gajula, M.D., 3318 Borden Apts., Third Avenue, Long Branch 07740. Osmania (India) 1970. Board eligible. Group, partnership, solo. Available.

Suryakumar Rajaram, M.D., 24 Wendy Lane, Charleston, SC 29407. Stanley Medical (India) 1969. Single specialty group, partnership, solo. Board eligible. Available January 1981.

Yousef Mardmomen, M.D., 113 Paulison Ave., Apt. K1, Passaic, NJ 07055. National Univ (Iran) 1972. Solo, multi-specialty group, academic. Available.

David I. Stolzenberg, M.D., 264-16 74th Avenue, Floral Park, NY 11004. Louvain (Belgium) 1976. Board eligible. Single or multi-specialty group, partnership. Available.

H. G. Tank, M.D., 111-28 66th St., Apt. 28, Forest Hills, NY 11375 MPS Med (India) 1974. Board eligible. Multi-specialty group, partnership, emergency room. Available.

M. Y. Najam, M.D., 4617 Shea Parkway, Corpus Christi, TX 78413. King Edward Med. (Pakistan) 1974. Board eligible. Partnership, Single specialty group, multi-specialty group. Available.

H. G. Levine, M.D., 2426 Lurting Ave., Bronx, NY 10469. Einstein, 1975. Board eligible. Single specialty, group, partnership. Available.

S. A. Rao, M.D., 950 49th St., Apt. 2G, Brooklyn, NY 11219. Bellary Med (India) 1974. Board eligible. Institutional, multi-specialty group, academic. Available.

PHYSICAL MEDICINE/REHABILITATION—Sonthineni Govardhan, M.D., 80-15 41st Avenue, Apt. 340, Elmhurst, NY 11373. Guntur (India) 1972. Board eligible. Multi-specialty group, partnership, institutional. Available.

PSYCHIATRY—Leroy J. Pelicci, M.D., P.O. Box 1357, Hershey, PA 17033. Pennsylvania State 1975. Partnership, single or multi-specialty group. Available July 1980.

Datta S. Raju, M.D., P.O. Box 1453, Montheagen Avenue, Middletown, NY 10940. Rangaraya (India) 1970. Board eligible. Single or multi-specialty group, partnership. Available.

Willy Krauss, M.D., 2907 Townway, Danville, IL 61832. Hadasah (Israel) 1965. Board eligible. Single or multi-specialty group, partnership. Available August 1979. Balasubramaniam Gulasekaram, M.D., Apt. 1-D, Beechwood Hall, Westchester City Medical Center, Valhalla, NY 10595. Colombo (Sri Lanka) 1970. Board eligible. Research, institutional, group. Available September 1979.

PULMONARY DISEASES—Saroj Sehgal, M.D., 299 South Harrison Street, Apt. 3-C, East Orange 07018. Maulana Alad (India) 1972. Subspecialty, internal medicine. Board eligible (IM). Multi-specialty group, institutional, solo. Available.

RADIOLOGY—Anil G. Desai, M.D., 701 Red Bank Avenue, Apt. G-10, West Deptford 08096. Baroda (India) 1972. Special interests—diagnostic radiology and nuclear medicine. Board eligible. Partnership, single-specialty, institution. Available.

R. Murty Krishnamsetty, M.D., 101 West 15th Street, Apt. 4-E North, New York, NY 10011. Banaras (India) 1971. Special interests—therapeutic radiology and nuclear medicine. Board certified. Research, institutional, multi-specialty group. Available.

Cyril Milunsky, M.D., 8 Old Colony Lane, Apt. 1, Arlington, MA 02174. Witwatersrand (South Africa) 1969. Board certified (diagnostic radiology). Single or multi-specialty group, partnership. Available.

Patrick F. Zazzaro, M.D., 6839 Shawnee Road, Richmond, VA 23225. CMDNJ-Rutgers 1975. Particular interest—diagnostic radiology. Board eligible. Group, partnership. Available July 1979.

Henry Mang, M.D., 8 Predmore Avenue, Colonia 07067. Sydney (Australia) 1965. Subspecialty, nuclear medicine. Board certified. Any type practice. Available.

RHEUMATOLOGY—Alan B. Fishman, M.D., 70 Centre Street, Apt. 2-D, Brookline, MA 02146. Subspecialty, internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available.

SURGERY, CARDIOVASCULAR—Cesar P. Veluz, M.D., 1200 North State Street, Box 1930, L.A. County USC Medical Center, Los Angeles, CA 90033. University of the Philippines 1971. Special interest, thoracic surgery. Board eligible (general surgery). Single or multi-specialty group, partnership. Available.

Naweed K. Majid, M.D., Box 85, USAF Hospital, USAF, APO NY 09220. King Edward (Pakistan) 1967. Special interest, thoracic surgery. Board certified (general surgery). Single or multi-specialty group, institutional. Available July 1980.

Peter Y. Chang, M.D., 3450 Wayne Avenue, Apt. 26-J, Bronx, NY 10467. Taipei (Taiwan) 1970. Special interest, general surgery. Board certified (general surgery). Any type practice. Available.

SURGERY, COLON/RECTAL—Sara I. Antoine, M.D., 2745 Birchcrest Drive, SE, Apt. 209, Grand Rapids, MI 49506. Damascus (Syria) 1971. Special interest, general surgery. Board eligible. Partnership, solo, multi-specialty group. Available August 1979.

SURGERY, GENERAL—Jong Chun Moon, M.D., 420 Stockholm Street, Apt. B-6, Brooklyn, NY 11237. Kyungbuk (Korea) 1968. Board eligible. Partnership, solo, multi-specialty group. Available.

Richard A. Dietrich, M.D., 2205 Madison Road, Cincinnati, OH 45208. Cincinnati 1972. Board eligible. Single-specialty group, partnership, solo. Available August 1979.

Ibibama E. Afonya, M.D., 5 Fairview Terrace, East Green Bush, NY 12061. Ibadan (Nigeria) 1970. Board certified. Partnership, single or multi-specialty group. Available July 1980.

Kautilya A. Mehta, M.D., 6 Ashwood Court, Summit 07901. G. S. Medical College (India) 1967. Board eligible. Partnership, single specialty group, research. Available.

Kalyanasundaram Venkataraman, M.D., 380 North Broadway, Apt. C-14, Yonkers, NY 10701. Madras (India) 1966. Board eligible. Solo, single or multi-specialty group. Available.

Luke J. Sheu, M.D., 2975 1/2 Northview Drive, Youngstown, OH 44504. Chung Shan (Taiwan) 1971. Special interest, emergency medicine. Board eligible. Partnership, multi-specialty group, emergency room. Available.

Ronald I. Leberman, M.D., 2300 Walnut St., Apt. 317, Philadelphia, PA 19103. Temple 1974. Board eligible. Partnership, single or multi-specialty group. Available.

Govindan Gandhi, M.D., 80 Guion Place, Apt. 12-P, New Rochelle, NY 10802. Thanjavur (India) 1973. Board eligible. Partnership, single specialty group, solo. Available.

Bose S. Mikkilineni, M.D., 555 Prospect Place, Brooklyn, NY 11238. Guntur (India) 1970. Special interest, abdominal surgery. Board eligible. Any type practice. Available.

Roshan H. Lalta-Singh, M.D., Roswell Park Memorial Institute, Buffalo, NY 14263. Kolhapur (India) 1968. Special interest, oncology. Board certified. Solo, partnership, multi-specialty group, institutional, public health. Available.

Young Nahm Lee, M.D., 1825 Parkside Drive, Apt. A-2, Park Ridge, IL 60068. Kyungpook (Korea) 1964. Special interest, general medicine. Board eligible. Partnership, multi-specialty group, solo. Available.

Kumar M. Nirmal, M.D., 220 Mount Vernon Place, Apt. 12-C, Newark 07106. K.G. Medical College (Lucknow, India) 1961. Board eligible. Single or multi-specialty group, solo. Available.

Joseph J. Rainone, M.D., 263-45 74th Avenue, Glen Oaks, NY 11004. SUNY-Upstate 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Thomas F. Street, Naval Regional Medical Center, FPO, San Francisco, CA 96652. George Washington 1972. Board certified. Multi-specialty group, partnership, research. Available.

Vithal D. Kardani, M.D., 133-52 Avery Avenue, Flushing, NY 11355. Jamnagar (India) 1972. House physician or residency. Available.

Vincent Larkin, Jr., M.D., 7021 Colonial Road, Brooklyn, NY 11209. SUNY-Downstate 1974. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available July 1979.

Geoffrey Simon, M.D., RFD 2, Box 155, Harrison, Maine 04040. Boston 1968. Board certified. Group, partnership, solo. Available.

Manuel V. Sarroca, M.D., 300-C Outer Belle Road, Trotwood, OH 45426. University of Philippines 1972. Board eligible. Solo, partnership, group. Available July 1979.

Wei H. Lee, M.D., 3001 S. Harrison Street, Denver, CO 80210. Taipei (Taiwan) 1966. Subspecialty, cardiovascular and thoracic surgery. Any type practice. Available July 1979.

Parvathareddy Ashok, M.D., 42-55 Colden Street, Apt. 9-E, Flushing, NY 11355. An-

dhra Medical (India) 1972. Board eligible. Partnership, multi-specialty group, solo. Available.

Michael F. Lane, M.D., 7901 Henry Avenue, Apt. C-411, Philadelphia, PA 19128. SUNY-Downstate 1971. Board eligible. Partnership, single or multi-specialty group. Available.

SURGERY, HEAD/NECK—Joseph B. Jacobs, M.D., 3241 Woodbine Street, Los Angeles, CA 90064. Einstein 1974. Subspecialty, otorhinolaryngology. Board certified (otorhinolaryngology). Partnership, research, multi-specialty group. Available.

SURGERY, ORTHOPEDIC—Rodolfo S. Polintan, M.D., 40-10 165th Street, Flushing, NY 11358. Santo Tomas (Philippines) 1970. Board eligible. Solo, partnership, single-specialty group. Available August 1979.

Sheroo Kohli, M.D., 5021 Aurora Avenue, Des Moines, Iowa 50310. G. S. Medical College (India) 1946. Board eligible. Group practice preferred. Available.

James K. Koh, M.D., U.S. Naval Reg. Medical Center, FPO, San Francisco, CA 96652. University of Pennsylvania 1972. Board certified. Single or multi-specialty group, partnership. Available August 1979. Nicholas Cappello, M.D., 663 Young Road, Erie, PA 16509. Creighton 1975. Board eligible. Single or multi-specialty group, partnership, research, public health, emergency room. Available July 1980.

SURGERY, UROLOGICAL—Steven H. Paletsky, M.D., 126-C Remington Avenue, Syracuse, NY 13210. South Carolina 1973. Board eligible. Partnership, solo, single-specialty group. Available.

John Thomas Sommer, M.D., 5325 N. Lakewood Avenue, Chicago, IL 60640. University of Virginia 1972. Partnership, research, single-specialty group. Available July 1980.

Ran Abraham, M.D., 420 East 80th Street, Apt. 8-1, New York, NY 10021. Lausanne 1974. Board eligible. Partnership, single-specialty group, solo. Available.

David J. Caro, M.D., 300 East 34th Street, New York, NY 10016. Cornell 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Vincent J. Lanteri, M.D., 689 Passaic Avenue, Clifton 07012. Guadalajara 1974. Partnership, single-specialty group, solo. Available July 1980.

UROLOGY—H. Barry Opell, M.D., 1275 East 51st Street, Brooklyn, NY 11234. Lausanne (Switzerland) 1971. Board certified. Solo, partnership, group. Available.

Manoj P. Khandherja, M.D., 2901 S. King Drive, Apt. 1818, Chicago, IL 60616. R. G. Kar Medical College (India) 1972. Board eligible. Any type practice. Available July 1979.

Stuart Bergman, M.D., 306 Eastbrook Drive, Charlottesville, VA 22901. Cornell 1973. Board eligible. Group or partnership. Available July 1980.

Canada's Declining Health Care System

May 9, 1979

Dear Dr. Krosnick,

You have asked me to comment on the paper entitled "The Health Care System in Canada: It Works" by Honorable John F. Brockelbank, which appeared in *The Journal* of the Medical Society of New Jersey in the April 1979 issue.

Mr. Brockelbank has traced the history and cast in a favourable light the health care legislation of the socialist government of Saskatchewan over the past few decades. Few could disagree that these praiseworthy initiatives of the Saskatchewan government provided leadership in this field for the other provinces of Canada and for the eventual participation of the federal government; and further, that hospitalization insurance, protection against the financial catastrophe of prolonged illness, and the more general availability of physicians' and diagnostic services have been of inestimable benefit to the citizens of this country.

But I would remind your readers that Mr. Brockelbank is a politician, a legislator, not the administrator of a health care institution nor a provider of health care. His narrative touches with only casual brevity the astonishing withdrawal of the federal government from active regulatory participation in national health care insurance, at its own initiative and within ten years of entry, in return for tax concessions and pro-rated grants to the provinces. It had become the guarantor of a shared enterprise it could not afford or control.

Mr. Brockelbank does not sit in the chair of a hospital administrator whose budget has been limited to a 3 percent increase for next year ("cap" in U.S. terms) with inflation running at least 9 percent and whose only option is to discharge staff and cut beds. Costs of national health insurance in the Canadian provinces have exceeded funds avail-

able from premiums or tax revenues and the principal stratagem employed by ministries of health is rationing. Immigration of physicians has been strictly limited, residency positions have been reduced, doctors' incomes have not kept pace with inflation or income of other trades and professions, and last year between 800 and 1,000 Canadian physicians left Canada for the United States.

All of us fervently hope, as Mr. Brockelbank does for Saskatchewan, that prevention of illness and injury will reduce health costs, but our record in controlling alcohol-related motor vehicle accidents, smoking, obesity, and cancer has not thus far been notably successful, and provides a rather tenuous basis for public policy.

Medical and hospital associations in Canadian provinces have taken the position that our health care system might be preserved by the infusion of private money into the system through user fees or co-insurance, but this has been resisted by elected officials because of its political unpopularity. The Canadian experience would indicate that once the public has become accustomed to first dollar coverage for hospital and medical services, there is no turning back. There is the dilemma—a declining health care system within a political framework which cannot or will not be changed.

If there is a lesson for your readers from the Canadian experience it is, in my opinion, that you should bend every effort to ensure that NHI, U.S. style, should embrace from the outset the principle of user participation in cost, on the part of those who can afford to pay. Many of us believe that if that had occurred in Canada we would not now be witnessing the deterioration of a system which was for a decade the finest in the world.

(signed) R.W. Gunton, M.D., F.A.C.P.
London, Canada.

High Voltage Lines and Cardiac Pacemakers

May 11, 1979

Gentlemen:

In recent years there have been some claims that the electric fields associated with high voltage overhead electric transmission lines might have an effect on cardiac pacemakers worn by persons on a transmission line right-of-way.

The New Jersey Board of Public Utilities has required that we notify appropriate medical authorities in the State of New Jersey that high voltage transmission lines should be added to other electric-field-producing equipment, such as microwave ovens, that should be avoided by pacemaker wearers. As further required by the Board, we also are sending a similar notification to pacemaker manufacturers.

If you have any questions on this subject, please contact Mr. R. O. Leinbach, Manager—Transmission Projects, PSE&G, 80 Park Place, Newark, New Jersey 07101 (201-430-7630).

(signed) C. G. Troxell

Meet, Eat and Retreat

May 20, 1979

Dear Sir:

I trust that I will have the strength and durability to make this third annual report to the general membership another chapter of a continuing service to those unable to attend our convention.

The 213th Annual Meeting of MSNJ presented the usual mixture of inaction and overreaction, with the customary press projection of our Society as a collection of indecisive nit-pickers.

The transactions of the House of Delegates will be published in *The Journal* with accurate reporting of the results. It is my purpose to editorialize, and hopefully offer constructive criticism of our failure to address adequately the

major problems faced by our profession.

My desire for definitive action on issues constantly pits me against the Board of Trustees, whom I feel to be too committed to policies of procrastination, compromise, and, occasionally, collaboration. My overview of this year's meeting leads me to the belief that, while the Board and I represent widely divergent philosophies, our positions are both based on sincere convictions. The Drs. Todd, Alessi, *et al.* should be relieved to hear that they are no longer the primary target of my critique.

The three major issues to which I devoted my energies this year were resolved as follows:

A Mechanism to Prevent the Board from Arbitrarily Overruling the House of Delegates—I introduced a Resolution to establish a policy which would, at minimal cost, preclude a repetition of the physicians' assistants fiasco. The best of the illogical objections raised, primarily by Board members, was that the Board's blunder was really a blessing in disguise, because it stimulated interest and exposure to the issue. The resolution was, nonetheless, defeated.

Mandatory AMA Membership—Last year's almost unbelievable passage of a resolution to make AMA membership compulsory, despite the established objection of an overwhelming number of grass-roots members was placed before the House as a proposed Bylaw change, requiring a two-thirds majority for adoption.

The opening Session of the House set the tone for debate. A variety of "honored guests" advocated UNIFICATION, an exceedingly inappropriate pseudonym for this extremely divisive issue.

Discussion from the floor established that Essex County had polled its entire membership, and found over 85 percent objecting to the proposal. An informal

poll of those attending the Hudson County annual meeting had shown no one in support. There is no reason not to assume that this reflects the sentiment throughout the State.

How did your *mis*-representatives vote on this issue? A *majority supported* it! Fortunately, thanks to impassioned pleas from a handful of us, the fateful two-thirds was not achieved.

National Health Insurance—My resolution #10 (1978) *opposing any type of* NHI had been referred to the Board last year. They took no action for twelve months. Their long-awaited response came in the form of a resolution, essentially reflecting the position of the AMA Board of Trustees, which differs little from the plans that Senators Long and Dole have already submitted, and is alarmingly similar to the proposal expected from President Carter and Califano, which they openly proclaim as phase one of a total federal takeover.

Our vocal coalition of Conservatives and Libertarians was able to beat back this latest example of the misdirection of organized medicine. A large part of the credit for this victory must go to a graphic pamphlet proclaiming federally controlled catastrophic health insurance to be a TRAP. When I called Frank Woolley, Executive Director of AAPS, to thank him for supplying the pamphlets, I bemoaned my frustration at failing with my one attempted "cure," and succeeding with only two "ounces of prevention." He told me that I should be congratulated, since someone had aptly described the usual organized medicine meeting as simply "meet, eat, and retreat." The House of Delegates reflects a common failing of most groups. Only about 10 percent have any actual input. The vast majority apparently consider the Annual Meeting as a prestigious tax deductible chance to get together with old cronies, wine and dine, and support those policies which best will accomplish

a slow orderly withdrawal from individual responsibility. "Helping the wife pack" and getting an early start for home take precedence over any business before the House at the often-vital closing session.

When the Board overstepped its authority, those in the House who objected were able to rectify the error. I contend that too many Delegates are misrepresenting or malrepresenting their constituents. This problem is due primarily to two factors. Most members do not expend the energy necessary to convey their views; those who do, find the Delegates too often unresponsive.

Since my focus this year is on the inadequacies of the House of Delegates, I offer my view of the proper function of a Delegate. He, or she, should represent the viewpoint of the membership of his county society when known, should seek out that position, if it is unclear, and should have the initiative to alter that position, when faced with reasonable arguments of opposition on the floor of the House. In the latter case, they should be held accountable for a valid explanation of their altered position.

My next criticism will sound harsh, but it is sadly true. We have too many "senile" Delegates, who for a variety of well-meaning reasons have been permitted to clutter the House as dead wood. The responsibility for replacing them must be shared by the nominating committees and the general membership. My plea becomes annually more desperate for active involvement of all MSNJ members, before it is too late.

In conclusion, I understand that there is a current rock hit, that says, in effect, "I want you, I need you, but there is no way I will ever love you," and vice versa. I intend to learn the tune, so that I can hum it as this year's theme-song, since its title is "Two Out of Three Ain't Bad."

(signed) Frank J. Primich, M.D.

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CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

MEDICINE (includes Family, Internal, and General Medicine and Dermatology)

Aug.

- IgE in Allergic Disease**
- 2 7:30 a.m.-5 p.m.
- 3 8 a.m.-5 p.m.
- 4 8 a.m.-4:30 p.m.
- 5 8-12 noon
Downingtown Inn, Downingtown, Pa.
(*Holy Name Hospital and AMNJ*)
- Renal Program Series**
- 7 12:30-1:45 p.m.—VA Medical Center,
East Orange
- 14 12:30-1:45 p.m.—CMDNJ-College
Hospital, Newark
(*AMNJ*)
- 17 **Acute Renal Failure**
12 noon—Freehold Area Hospital
(*AMNJ*)

Sept.

- 6 **Psychoendocrine Findings**
- 13 **Drug Incompatibilities**
- 20 **Advances in Neurology**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation*)
- 15- **Multiple Sclerosis Symposium**
- 16 9 a.m.-5:30 p.m.—VA Medical Center,
East Orange
(*VA Medical Center and AMNJ*)
- 17 **Hypokalemic Alkalosis**
12:30-1:30 p.m.—West Hudson
Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 19 **Medical Grand Grounds (Pulmonary
Disease Section)**
11:30 a.m.-1 p.m.—VA Medical Center,
East Orange
(*VA Medical Center and AMNJ*)

Advances in Infectious Diseases

- 24 8 a.m.-4:30 p.m.
- 25 9 a.m.-4:45 p.m.
- 26 9 a.m.-12 noon—Resorts International,
Atlantic City
(*CMDNJ-NJ Medical School, St.
Michael's Medical Center, Newark and
AMNJ*)
- 26 **Diagnosis and Treatment of Infectious
Disease**
9-11 a.m.—Roosevelt Hospital, Menlo
Park
(*Middlesex General Hospital and AMNJ*)

NEUROLOGY/PSYCHIATRY

Aug.

- 1 **Child Psychiatry Case Conference Series**
- 8 8:30-10:30 a.m.—Trenton Psychiatric
Hospital
- 15 (*Trenton Psychiatric Hospital and
AMNJ*)
- 22 **Phenomenology in Psychiatric
Differential Diagnosis, Part II**
- 9 **Role of the Hypothalamus in Health and
Disease**
- 16 **Therapeutic Community**
- 23 **Hyperactive Child Syndrome**
- 30 **Depression**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation*)
- 7 **Psychiatric Case Conference**
- 14 7:30-9:30 a.m.—Trenton Psychiatric
Hospital
- 21 (*Trenton Psychiatric Hospital and AMNJ*)
- 28

Sept.

- 5 **Suicidal and Homicidal Patients**
- 19 **Dx and Rx Agoraphobia**
- 26 **Obsessive Compulsives and Phobias—
Flooding**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 20 **Psychoanalytic Theory of the Instinctual
Drive**
8:30-10:30 p.m.—Hackensack Hospital
(*NJ Psychoanalytic Society and AMNJ*)
- 27 **Laboratory Use in Clinical Psychiatry**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation*)

OBSTETRICS/GYNECOLOGY

Aug.

- 1 **Combined Grand Rounds in Ob/Gyn**
- 8 3-5 p.m.—Rotates between CMDNJ-
College Hospital, Newark Beth Israel
22 and St. Michael's Medical Centers,
29 Newark, St. Joseph Hospital and
Medical Center, Paterson and Jersey
City Medical Center
(*CMDNJ and AMNJ*)
- 2 **Grand Rounds in Ob/Gyn**
- 9 4-5 p.m.—CMDNJ-College Hospital,
16 Newark
23 (*CMDNJ and AMNJ*)
30

Sept.

- 5 **Combined Grand Rounds in Ob/Gyn**
- 12 3-5 p.m.—Rotates between CMDNJ-
College Hospital, Newark Beth Israel
19 and St. Michael's Medical Center,
26 Newark, St. Joseph Hospital and
Medical Center, Paterson and Jersey
City Medical Center
(*CMDNJ and AMNJ*)
- 6 **Grand Rounds in Ob/Gyn**
- 13 4-5 p.m.—CMDNJ-College Hospital,
20 Newark
27 (*CMDNJ and AMNJ*)
- 13- **Fifth Annual Ignatz Semmelweis**
- 16 **Obstetrical Seminar**
Cherry Hill Inn, Cherry Hill
(*CMDNJ and AMNJ*)

SURGICAL SPECIALTIES (includes ENT, neurosurgery, ophthalmology, orthopedic, plastic, and vascular surgery)

Aug.

- 7 **Tumor Conferences**
- 14 11 a.m.-12 noon—Morristown
- 21 Memorial Hospital
- 28 (*Morristown Memorial Hospital and
AMNJ*)
- 17 **Monthly Tumor Conference**
12 noon-1 p.m.—Elizabeth General
Hospital
(*Elizabeth General Hospital and AMNJ*)

Sept.

- 13 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital,
Kearny
(*West Hudson Hospital and AMNJ*)

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Dr. Albert G. Hulett

At the grand age of 89, Albert G. Hulett, M.D., a member of our Essex County component, died in Presbyterian Hospital, Newark, after a long illness. A graduate of New York Medical College, class of 1912, Dr. Hulett pursued further study in internal medicine and pathology, becoming board certified in both clinical and anatomical pathology. He established a practice in Orange and until retirement had been affiliated with the Hospital Center there and with Presbyterian Hospital in Newark, and with the Jersey Shore Medical Center. He was a Fellow of the American College of Physicians and of the American College of Pathologists, and a member of the American Society of Clinical and Anatomical Pathologists. He had been active in medical affairs and long had been a representative of his county at MSNJ's House of Delegates. In 1962 he was a recipient of this Society's Golden Merit Award indicating fifty years of medical practice. Dr. Hulett served in the department of medicine of the Army of the United States in both World War I and World War II.

Dr. A. M. K. Maldeis

On May 1, A. M. K. Maldeis, M.D., a member of the Camden County Medical Society, died in West Jersey Hospital after a brief illness. A native of Camden and a graduate of Hahnemann Medical College in 1914, Dr. Maldeis did graduate work at New York Ophthalmic College and practiced that specialty in Had-donfield for many years. He was a Fellow of the American College of Surgeons and of the International College of Surgeons and had been chief of ophthalmology at West Jersey Hospital until retirement in 1957. He had been president of the staff and a member of the board of trustees of the hospital. Dr. Maldeis was a founder and past president of the New Jersey Ophthal-

mological Society and was a member of the American Academy of Ophthalmology. He had served a term as president of his county medical society. Dr. Maldeis was 87 years old at the time of his death.

Dr. Martin R. Rush

Martin R. Rush, M.D., a member of the Monmouth County Medical Society, died suddenly on March 13 in Riverview Hospital, Red Bank, where he had been a member of the staff. Born in New York City in 1912, Dr. Rush was graduated from Hahnemann Medical College, class of 1941, and pursued graduate work in anatomical pathology, becoming board certified in that specialty. He was a Fellow of the American College of Pathologists and of the American Society of Clinical Pathologists and a member of the New York Academy of Science. He was assistant clinical professor of pathology at Rutgers Medical School, and in addition to Riverview Hospital, had been affiliated with Monmouth Medical Center in Long Branch and the Paul Kimball Hospital in Lakewood. During World War II, Dr. Rush served with the department of medicine of the United States Air Force.

Dr. Vincent R. Tanzi

Vincent R. Tanzi, M.D., a member of our Union County component, died on May 18 in Kennedy Medical Center, Edison, where he was director of the family practice program and on the staff in the departments of medicine and pediatrics. A native of Pennsylvania, Dr. Tanzi was graduated from Georgetown University Medical School, class of 1951, and took a residency in pediatrics at St. Michael's Medical Center, Newark. He had been in private practice in Colonia before accepting appointment to a full-time position at the Kennedy

Medical Center. He formerly had been chairman of the department of pediatrics and vice-president of the medical staff at the Rahway Hospital. Dr. Tanzi was clinical assistant professor in pediatrics at the New Jersey Medical School, CMDNJ. He was 54 years old at the time of his death.

Dr. William Yudkoff

One of Hudson County's senior members, William Yudkoff, M.D., died in Bayonne Hospital on March 3 after a prolonged illness. Born in 1906 and graduated from the Medical School of the University of Maryland in 1929, Dr. Yudkoff pursued a career in radiology and was board certified in that specialty. He was a Fellow of the Radiological Society of North America and had been chief of radiology at Fairmount and Jewish Hospitals in Jersey City. Dr. Yudkoff served in the medical department of the United States Air Force during World War II.

Dr. Frank Zimmer, Jr.

At the untimely age of 49, Frank Zimmer, Jr., M.D., director of the department of psychiatry at Jersey Shore Medical Center and a member of our Monmouth County component, died on May 7. A graduate of New York University School of Medicine, class of 1955, Dr. Zimmer pursued graduate work in general surgery at Manhattan Veterans Administration Hospital and in hand surgery at Roosevelt Hospital, New York. He entered private practice in Spring Lake and was affiliated with Jersey Shore Medical Center and the Point Pleasant Hospital. From 1973 to 1975 he participated in a residency program in psychiatry at Rutgers Medical School and upon completion returned to Monmouth County (Sea Girt) to practice in that field.

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The Health Robbers.

Stephen Barret, M.D. and Gilda Knight. Philadelphia, George F. Stickley Co., 1978. Pp. 340 (No price given)

The book is a special publication of the Lehigh Valley Committee Against Health Fraud, Inc., which holds the original copyright. Its intended audience is the lay consumer of health services and doctors, and especially beginning medical students. Its purpose is educational so that readers may become more sophisticated in discriminating between *bona fide* and quack medical/nutritional health service and products and their respective promoters.

Twenty-three authors with good credentials in their fields have contributed the separate self-contained chapters which comprise the book. In part one, eighteen chapters are devoted mainly to discussion of how "the health robbers" exploit the miracle-seeking gullible in many areas such as: cures for incurable cancer and arthritis; fad diets and miracle weight loss schemes; phoney sex clinics; phoney experts on vitamin and food supplements; acupuncture cures and anesthesia; gadgets for spot-reducing and bust developing; and others. Additional chapters are devoted to helping readers spot doctor imposters, faith healers, and other unqualified "practitioners."

Part two of the book discusses what is being done to protect consumers of health services against fraud and why more is not being done. The final chapter is devoted to a discussion of how to achieve communication with and satisfaction from one's own physician.

There is some unevenness in the level of sophistication of presentation. There are chapters addressed to the lay reader on a level which tends to have gossip-column fascination because the names of so many popular patent medicines and well-known health/nutrition "oracles" are mentioned and attacked. However,

many chapters present well-developed arguments backed by citations of fact and research findings. In general each chapter tries to define the scope of its subject matter clearly, provide examples, give a clear explanation why the quackery under discussion has historically thrived and can continue to flourish, and give readers guidelines for recognizing or suspecting related hokum. A brief list of inexpensive recommended reading follows the majority of chapters.

All sections are readable and the organization of the book invites browsing. As a whole it represents a good survey of a solid introduction to the subject of medical/nutrition/health quackery. Physicians should find it a useful volume to which to refer patients.

Julio del Castillo, M.D.

The Hyperactive Child and the Learning Disabled Child

Paul H. Wender, M.D. and Esther H. Wender, M.D. New York, Crown Publishers, 1978. Pp. 138. (\$6.95)

This is a good book. Though subtitled "A Handbook for Parents," there is much useful information for physicians who see children. Most impressive is the skill with which the Drs. Wender so clearly describe the wide range of problems encountered by the children and their families and how to deal with such problems. Among the topics are stimulant medication (strongly favored), tranquilizers, side effects of medication, megavitamins, caffeine, discipline, behavior modification, psychotherapy, allergy, hypoglycemia, lead poisoning, and, briefly, neurotransmitters. From a thorough understanding of current knowledge on each issue comes good common sense and advice for families.

The liberal use of well-chosen analogies and examples clarifies the material and makes for interesting reading. Helping such children requires a considerable feeling for the many associated difficulties and parental concerns. This volume can assist physicians as well as parents in developing a deeper understanding of a widespread complex problem.

Damon M. Fellman, M.D.

Norethindrone: The First Three Decades.

Mary Jean Pramik, Editor. Palo Alto, CA, Syntex Laboratories, 1978. Pp. 100. Illustrated. No charge.

Although this book is distributed gratuitously to physicians by Syntex Laboratories of Palo Alto, CA, it contains a great number of worthwhile facts.

The first chapter recalls the development and synthesis of norethindrone (hereafter abbreviated to "n."), which first was marketed under the trademark Norlutin® by Parke, Davis and Co. The first workers that recognized the contraceptive property of n. were Gregory Pincus and John Rock, both of Boston. Later it was found that the combination of n. with mestranol was particularly effective in preventing pregnancies and the drug today is found in the great majority of oral contraceptives as the progestational component, whereas mestranol is the estrogenic part of the pill. Most of the oral contraceptives contain 1 mg of n. whereas the dose of mestranol varies from 50 to 80 mcg. They are marketed by Syntex under the name of Norinyl®, and since Ortho Pharmaceutical Corp. operates under the same license, their product, Ortho-Novum®, has the identical composition as Norinyl®.

In the chapter on biology we learn

that the drug causes glandular development in the uterus of estrogen-primed animals and also causes growth of the prostate, since it is both progestational and androgenic. Because n. attaches itself to the estrogen receptors it will have an anti-estrogenic effect besides its progestational action. In the late sixties experiments with the "minipill" were started, which represents one-half of the usual dose of n., namely 0.5 mg, which is combined with 35 mcg of ethinyl estradiol and distributed as Brevicon® tablets. However, this pill has a higher pregnancy rate and because of intermenstrual bleeding and spotting it has a serious drawback. It should be mentioned that n. is used in a number of gynecological conditions, such as amenorrhea, uterine hypoplasia, and menometrorrhagia.

In the sixth chapter on "Metabolic Effects," the formation of blood clots, which is one of the most feared complications when taking oral contraceptives, has not been observed when n. is used alone, but only in the combination of it with an estrogenic compound. As a matter of fact, when the drug alone was given, "all clotting and platelet parameters became significantly reduced," thus causing the opposite of blood clotting. Therefore, the researchers feel that blood clotting is due to the estrogenic compounds. Contrary to other oral contraceptives n. does not seem to affect the "various factors of carbohydrate metabolism" and the appearance of diabetes, whether latent or overt, cannot be attributed to n.

This reviewer has learned a great deal from perusing this book and any physician who either dispenses or prescribes oral contraceptives should read it. It may be worth your while the next time the Syntex representative comes around, to ask him for a copy of this book.

Werner Steinberg, M.D.

Principles of Clinical Electrocardiography, 10th edition

M.J. Goldman. Los Altos, CA, Lange, 1979. Pp. 415. Illustrated. (\$12)

This most recent edition of Goldman's widely read text is a very good book. As indicated in the preface, it presents basic and even complex ideas in a simple yet not simplistic manner. The discussions of clinical applications are

especially refreshing and unexpectedly comprehensive for a book that allegedly is devoted to electrocardiography alone. As with any other comparable text, there is a certain unevenness; for example, the chapters on contour analysis are clearly superior to those that deal with arrhythmias.

The first four chapters present basic cardiac electrophysiology in an easy-to-read yet detailed fashion. Regrettably, there is no discussion of calcium-dependent slow channel depolarization, a relatively new concept that provides a rational explanation for a wide variety of reentry mechanisms.

Chapters five through eleven provide a solid approach to the analysis of normal and abnormal electrocardiographic patterns. Unlike the enormous plethora of ECG monographs that have glutted the market, there are very few errors to be found in these chapters. Goldman would have us believe that the SA node is an endocardial structure (p. 36), when it is actually the only *subepicardial* part of the entire conduction system. Persistence of the "juvenile T wave pattern" is *not* specific for blacks (p. 74). The differential diagnosis between left atrial hypertrophy and intra-atrial block, an impossible task on electrical grounds alone, is confusingly described (p. 85). Figure 8-28 (p. 107) is *not* an example of superior axis since the mean frontal plane QRS axis is a meager minus 35 degrees. In his discussion of complicated right bundle branch block, Goldman adroitly avoids the sticky problem of right ventricular hypertrophy plus right bundle branch block. The widespread use of the anachronistic term, "perinfarction block" (pp. 130, 201 and elsewhere) must be condemned. Figure 9-23 (p. 132) is labelled "left posterior fascicular block," but the marked right axis deviation is more likely due to lateral infarction. The description of normal, infarctional, and non-infarctional Q-waves is inappropriately sketchy and weak (pp. 188-191). The same comment pertains to infarction with left bundle branch block (pp. 193-194). The author also avoids the thorny problem of left anterior fascicular block with and without inferior infarction (pp. 198-200).

The chapters devoted to arrhythmias (12 through 17) are not nearly as pithy as those just described. This portion of the book is replete with obsolete terms such as premature contractions, wandering pacemaker, multifocal and flutter-fibrillation. The paragraph on sinus arrhythmia (p. 208) fails to mention the

non-respiratory form. The abbreviated description of the bradycardia-tachycardia syndrome (p. 219) is dreadfully incomplete. Most arrhythmologists would convulsively refute the statement that: "Basically, there is no difference between atrial tachycardia and atrial flutter except for the atrial rate" (p. 221). The all-too-brief section on atrial fibrillation (pp. 223-228) makes little or no mention of the coarse and fine varieties, the Ashman phenomenon, nor of atrial fibrillation with a regular ventricular response, repeated description of high, middle, and low junctional beats is, of course, archaic (pp. 238-242). After more than a decade of looking at AIVR, I yet have not seen a single instance where "It may be impossible to differentiate an accelerated idioventricular rhythm from an AV junctional rhythm with aberrancy of intraventricular conduction without a His bundle recording" (p. 259). A flood of semantical waters seems to drown the section on atrioventricular dissociation, a subject that no author handles well (pp. 264-265). Types A and B of the WPW syndrome are determined by the polarity of the delta waves, *not* the R-waves (p. 267).

Figures 16-22 and 16-13 (p. 272) allegedly show isolated and alternating preexcitation beats; these could also be late ventricular premature impulses. Chapter 17 is, again, very incomplete; it attempts to deal with one of the most difficult problems in arrhythmology, aberrancy versus ectopy, but falls far short of the mark.

"Miscellaneous Abnormal Electrocardiographic Patterns" (Chapter 18) is highly selective but is reasonably well done. I doubt that one can differentiate pericarditis from infarction by the shape of the ST segment elevation (p. 278). Figure 18-2 (p. 279) purportedly represents acute pericarditis but could also be a normal ST variant. There is no mention of the differential diagnosis between chronic pericarditis and nontransmural infarction! The paragraphs on digitoxic arrhythmias need to be revised (p. 285). Non-paroxysmal junctional tachycardia is an extremely common manifestation of this problem, whereas atrial flutter and fibrillation are very rare. The chapters on pacing and vectorcardiography (19 and 20) are necessarily brief but surprisingly complete.

The test cases (Chapter 21) are superb; I would suggest that, in the next edition, the interpretations be kept separate from the electrocardiograms in order to prevent cheating. The lower case on p. 360 is paroxysmal, coarse atrial fibrillation,

not flutter-fibrillation. The lowest case on p.361 is more likely inferior infarction than anterior fascicular block since there are embryonic R-waves in inferior leads. The middle case p. 362, has an axis of minus 40 degrees, that is not quite "superior." Upper case, p. 363, has a weird frontal plane for uncomplicated mitral stenosis. Lower case, p. 368, could be interpreted as combined ventricular hypertrophy. Lower case, p.371, is clearly atrial flutter, not atrial tachycardia. The inferior infarction seen in the upper tracing, p. 373, is not mentioned. Chronic lung disease is favored over anterior infarction in the upper case, p. 374, because the Q-waves are slender and show no evidence of initial delay.

The Appendices (First and Second) are marvelous digests of all of the aforementioned material. The references are remarkably incomplete and relatively ancient; they need to be amplified and updated.

I recommend this book to cardiac nurses and to undergraduate and graduate physicians. It fills a huge void between the oversimplified primers and the oversophisticated tomes. The price is right, the figures are incredibly good, and the text is concise and lucid. Dr. Goldman's revised text will appeal to all but the virtuoso electrocardiographer.

Edwin L. Rothfeld, M.D.

Psychiatry for the Primary Care Physician.

A.M. Freeman, R.L. Sack, and P.A. Berger, Editors. Baltimore, Williams & Wilkins Co., 1979. Pp. 422. (\$19.95)

How refreshing it is to have a handsomely printed book on a technical subject that one actually can read with continuity. The title of this book does not do it justice inasmuch as it is really a comprehensive treatise and yet presented so that the non-psychiatric physician has no difficulty following its thought and contents.

Each chapter (written by a different expert in the field) is so organized as to meet practical needs in the ordinary practice of medicine. For example, there is an excellent chapter on behavioral medicine which includes such aspects of health enhancement as a smoking cessation program; stress management program; and an adherence counseling program.

Another very vital chapter is directed toward the emotional aspects of surgery and includes the attitudes of the surgeon; preoperative preparation; and the various aspects of postoperative psychiatric consultations.

This is not a psychiatric textbook in the classical sense in that it proceeds from classification to classification but rather is a practical manual but yet very sophisticated in its content. It should be in the "must have-must read" category for the non-psychiatric physician.

Seymour F. Kuvin, M.D.

Annual Review of Neuroscience

W. Maxwell Cowan, Editor. Palo Alto, CA, Annual Reviews, Inc., 1979. Pp. 555. Illus. (\$17)

Each of these seventeen chapters is a scholarly and sophisticated review of a current topic condensed to between twenty and fifty pages. The authors are recognized experts who assume that the reader is familiar with basic neuroscience. The subjects are diverse, including among others, mania and depression as an inherited biochemical disorder, the mechanism of fast axonal transport, neurotransmitter biochemistry, CNS slow viral infections, physiology of vision, enkephalin and other endogenous opioids, and a conceptual framework for understanding the behavior of newborns. The information is tightly packed and does not make for light reading. As a practicing neurologist, I found this volume interesting, for it provides a critical analysis of many

assumptions employed in medical practice. However, because of the complex basic science material, the *Annual Review* is intended more for the research neuroscientist than the clinician. By current standards, the cost is more than reasonable.

Damon M. Fellman, M.D.

Physician's Handbook, 19th Edition.

M.A. Krupp, M.J. Sweet, E. Jawetz, E.G. Biglieri, R.L. Rowe, and S.A. Camargo, Editors. Los Altos, CA, Lange, 1979. Pp. 758. Illustrated. (\$9)

This 19th edition of *Physician's Handbook* is a renewal of an old friendship that goes back for some of us over the past 38 years!

Its size, 11 x 17.5 x 2.5 cms, is still compact enough to fit into a laboratory or hospital coat pocket, or the purse or bag of the nurse attendant. Its practicality has been proved over the years—as necessary to have in hand as the stethoscope that we carry in our other pocket, or the diagnostic instruments in our examination rooms.

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This handbook is recommended for all who are involved in patient care or medical education in hospital, office, or school. For its size, content, and cost, it is excellent value.

Harry M. Poppick, M.D.

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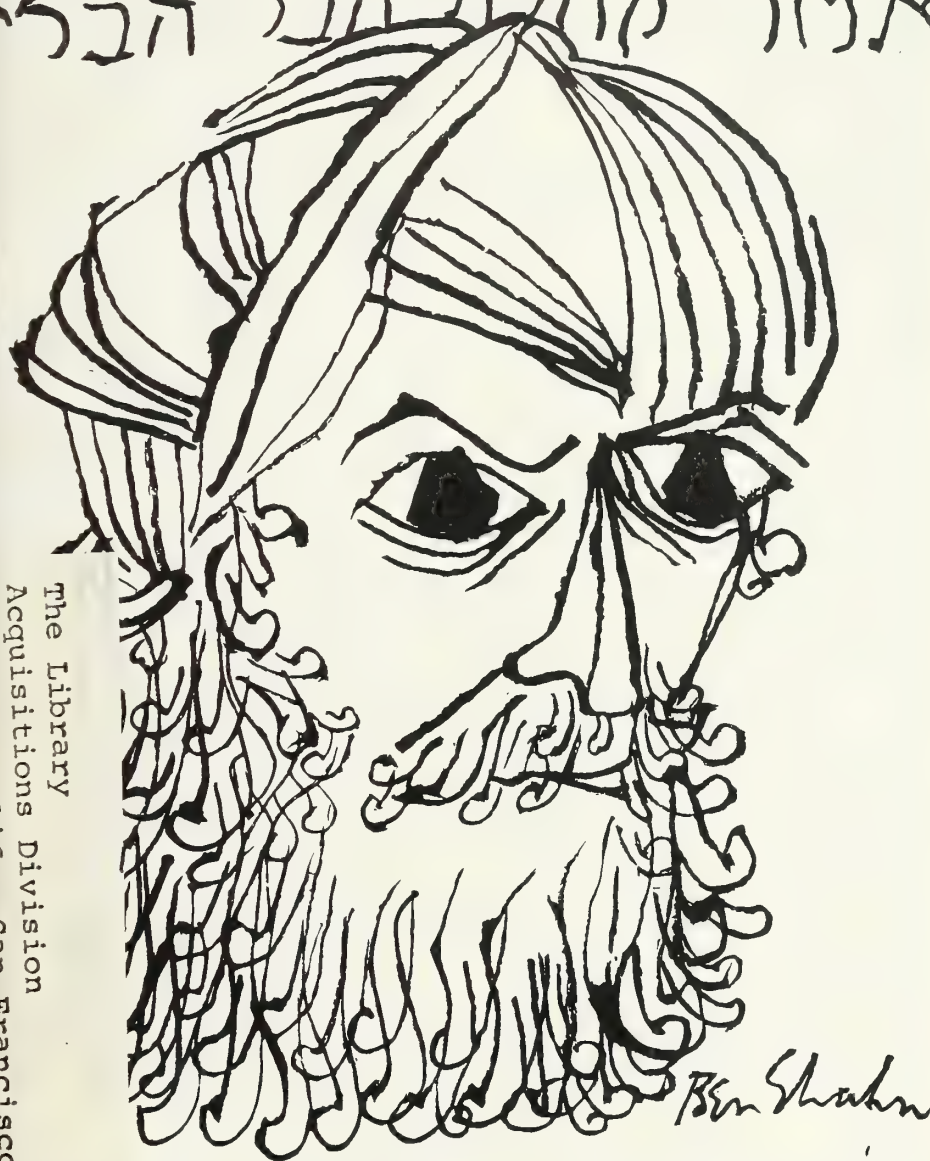
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October 11, morning

Moderator: Stephen Cisternino, M.D.

Global Abdominal Anatomy by Ultrasound and Computed Tomography — Morgan Dunne, M.D.

Computed Tomography of Trauma — Edward Druy, M.D.

New Developments in CT Technology — John Perry

The Use of CT in Radiation Therapy Planning — Ralph Scott, M.D.

October 11, midday: Workshop sessions at the University of Maryland Hospital and Johns Hopkins Hospital will demonstrate CT diagnostic activities in clinical settings.

Location: INTERNATIONAL HOTEL, Baltimore-Washington International Airport.

Pre-registration: Early pre-registration by mail is encouraged since conference facilities necessitate limited enrollment. Registration, with a \$15 late fee, will be possible on a space available basis at the International Hotel, 7:30 am, October 10 and 10:00 am, October 11.

Fee:

	Physicians	Residents, Interns and Other Professionals
Full 3-day course:	\$200	\$135
Body CT session only:	\$125	\$ 80
Neuro CT session only:	\$125	\$ 80

The total registration fee, payable in advance, includes the cost of instructional materials, coffee breaks, lunches, and reception.

Credits: 20 credit hours in Category I of the Physician's Recognition Award, American Medical Association, for the entire course.

Supported by an educational grant from Pfizer Medical Systems, Inc.

October 11, afternoon

Moderator: Krishna C.V.G. Rao, M.D.

Functional CT Anatomy — Mokhtar H. Gado, M.D.

Sensitivity and Specificity of CT Scanning in Intracranial Neoplasm — Sadek K. Hilal, M.D., Ph.D.

CT in Sellar and Parasellar Lesions — Fred J. Hodges, III, M.D.

Normal and Abnormal CT Anatomy of Intracranial Structures — Sadek K. Hilal, M.D., Ph.D.

October 12, morning

Moderator: Richard F. Mayer, M.D.

CT in Stroke — Irvin Kricheff, M.D.

Intracranial Anomalies — Derek C. Harwood-Nash, M.D.

CT in Certain Pediatric Conditions — Krishna C.V.G. Rao, M.D.

Moderator: Harvey H. Levine, M.D.

CT in Head Trauma — Pulla R.S. Kishore, M.D.

CT in Degenerative Brain Disease — Giovanni DiChiro, M.D.

CT in Infection — S.H. Lee, M.D.

October 12, afternoon

Moderator: Thomas B. Ducker, M.D.

Computed Tomography/Metrizamide in Evaluation of Pediatric Spine — Derek C. Harwood-Nash, M.D.

CT/Metrizamide in the Adult Spine — Mokhtar Gado, M.D.

Use of Metrizamide and Alternative Methods of Evaluating Posterior Fossa Lesions — Irvin Kricheff, M.D.

Recent Trends in Neuro-imaging Modalities — Giovanni DiChiro, M.D.

Moderator: Giovanni DiChiro, M.D.

Panel Discussion

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The Ben Shahn-Stefan Martin wood engraving, "Maimonides," with calligraphy is reproduced with permission of Stefan Martin and Visual Artists and Galleries Association, Inc. (VAGA), trustee for the estate of Ben Shahn. Inquiries may be sent to Mr. Martin in Roosevelt, New Jersey 08555, or VAGA, One World Trade Center, New York, New York 10048.

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Product Information as of January, 1978

References:

1. Meyer, C.: American Folk Medicine. Scarborough, New York, Plum Books — New American Library, 1975, p. 208.
2. Data on file, MERRELL-NATIONAL LABORATORIES
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Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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Moshe ben Maimon Ha-Sepharti (Maimonides)

Our cover is a reproduction of a wood engraving in black and sepia entitled "Maimonides with Calligraphy" by the late Ben Shahn and Stefan Martin.¹ Known among many Jews as "Rambam" (an acronym from the initial consonants of his name—Rabbi Moses Ben Maimon), Maimonides, according to Arabic historians, was one of the most prominent physicians of his time.²

Born in Cordova, Spain in 1135 C.E., he emigrated with his family to Acco, Palestine in 1165 C.E. Rambam, "the greatest Jewish philosopher of all times" was also "a pre-eminent religious authority" and a "proficient mathematician."² He did his greatest work and established his fame, however, in old Cairo, Egypt. Maimonides became the chief rabbi of Kahira and ultimately became the court physician to Saladin (Sultan Saladin Jussuf ben Ajub) and later to his successor, the vizier Alfadhel. He was invited to become his "physician inordinary" by King Richard the Lion-Hearted, but Rambam declined the offer.

The published works of Maimonides, who died at the age of sixty-nine in Cairo, fall into three categories—religious, philosophical, and medical. His great religious work, *The Mishna Torah*, is a complete code of Jewish Law. *The Moreh Nebuchim* or *Guide to the Perplexed* was Maimonides' greatest philosophical treatise.

The medical works of this remarkable man, as listed by Glick, included the following:

1. Commentary on Hippocrates
2. Compend of Galen
3. Works on Hygiene
4. Consultation on Various Accidents
5. On Foods
6. On Medicaments
7. Sefer Nassamin of Toxicology
8. On Hemorrhoids
9. On Gout
10. On Sexual Relations
11. On Asthma
12. On Psychology

Among the chapters in these books, one finds everything from anatomy and burns to urine, vomiting, and women. As a physician, Maimonides deviated from his contemporaries in his opposition to poly-pharmacy, a kind of "shot-gun medicine" of the time, and advocated "nature-cure" while seeking the etiology of disease. It is remarkable that this ancient physician-philosopher believed that lack of exercise and excesses—of food, alcohol, and sex—were responsible for the cause of most diseases. His concept is still valid some 800 years later.

Ben Shahn, a great New Jersey artist, had many of the characteristics of Maimonides. Born in Kovno, Lithuania in 1898, Shahn came to the United States at the age of eight. In

Europe, his education consisted mostly of Biblical studies. His love of letters flourished during his high school days when he was apprenticed to a lithographer. Although he studied graphic and fine arts, Shahn became so interested in the biological sciences during his study periods at New York University, the City College of New York, and the Marine Biological Laboratory at Woods Hole, Massachusetts, that he almost pursued a career in biology. Shahn spoke eloquently of his philosophy toward the "political and social implications of contemporary events" through his works of art, many of which are in the permanent collection of the New Jersey State Museum in Trenton.¹ One of his finest is entitled "Prenatal Clinic," a statement as valid today as it was in 1941.

Shahn's New Jersey roots were planted in 1939 when he moved from New York City to the village called "Jersey Homesteads," later renamed Roosevelt. This community was "designed and built as a cooperative commune for unemployed garment workers of New York's Lower East Side." It was in Roosevelt that Shahn painted a large fresco mural for the community center in 1937 on a commission by the Farm Security Administration. Shahn maintained his permanent residence and studio in Roosevelt until his death in 1969.

The Hebrew calligraphy, which was engraved by Stefan Martin, a protege of Shahn's who lives and works in Roosevelt, is from *Ecclesiastes*, 1:1-2 and reads, (in the King James' Version):¹

"The words of the Preacher, the son of David, King in Jerusalem.
Vanity of vanities, saith the Preacher,
Vanities of vanities; all is vanity."

In its old sense, according to Fowler, vanity referred to *futility and waste of time*, as opposed to the modern implication of *conceit*.³ For the modern physician, all is *not* a waste of time. We have much to do and much to learn, but we must not be conceited.

Moshe ben Maimon was a great physician, philosopher, and religious authority. Ben Shahn was a great artist, philosopher, biblical student, and social commentator. We modern physicians can learn much from both of these role models, who were separated from each other by more than seven centuries.

A.K.

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- ¹Prescott KW: *The Complete Graphic Works of Ben Shahn*. New York, The New York Times Book Company, 1973, p. 194.
- ²Glick SS: The Jew in medicine. *Phi Delta Epsilon News and Scientific J* 70:19-25, 1978.
- ³Fowler HW: *A Dictionary of Modern English Usage* 2nd Ed. New York and Oxford, Oxford University Press, 1965, p. 671.

You Can Fight City Hall

The siren song of "federal funds" is a very difficult thing for state government officials to resist, even if it threatens the very foundation on which America was built, namely, *voluntarism*, which goes back to the days of Ben Franklin. The issue was Emergency Medical Services (EMS) and the bait was \$2 million in federal funds.

The Emergency Medical Services Systems (EMSS) Act of 1973 (P.L. 93-154) "provided aid to states and sub-state areas to establish coordinated, cost-effective, area-wide emergency medical services systems." Through this legislation and these funds, the EMS unit in New Jersey's State Department of Health was spawned. A revised version of the EMS Regionalization Regulation for the Designation of EMS Regions and Hospitals, dated February 14, 1979, was proposed and promptly earned the enmity of 116 hospital members of the New Jersey Hospital Association which violently opposed the plan. An Ad Hoc Committee on EMS Regionalization Proposal of the Medical Society of New Jersey, under the leadership of its chairman, Alfred A. Alessi, M.D., voted not to accept the proposal. The most dramatic opposition to the plan was demonstrated by some 200 ambulances from volunteer rescue squads around the state. They headed for the John Fitch Way Plaza State Department of Health Office complex, but only 100 were permitted to parade around the area while the Health Care Administration Board met to vote on the proposal.

The plan to be developed by Health Systems Agencies (HSAs) would regionalize emergency medical services and realign the relationships between the volunteer ambulance squads, the mobile intensive care units (MICU) and paramedics, the hospital emergency departments, and the communicators and the dispatchers. A three-tiered system—

resource hospitals, associate hospitals, and receiving hospitals—would be designated and very strictly controlled. A hierarchal relationship would exist between designated hospitals, whose functions would be delineated clearly. One resource hospital would be identified for an entire EMS region (750,000 population) and one associate hospital per 250,000 population in that region would be named. Critical care categories were defined.

The proponents of the plan felt the new system could save a thousand or more lives per year through the availability of trained paramedic teams and an efficient communications and dispatch technique. The hospital designations would provide the needed skills, personnel, and services to meet the needs of each critical care category. The system would be cost effective.

The MSNJ Ad Hoc Committee voted down the proposal and suggested it would support the EMSS Regionalization Proposal if "the recognized segments of the medical profession existing on a statewide basis (MSNJ, the New Jersey Association of Osteopathic Physicians and Surgeons, and the specialty societies) be granted input into the development, the approval, and the implementation of the detailed plan for the various systems to be developed under the EMSRP."

The volunteer rescue squad members saw the plan as the beginning of the end to the system of voluntarism in the emergency medical services field in New Jersey.

Taking all facts into consideration—despite pressure from the State Health Commissioner and other State Health officials—the Health Care Administration Board voted down the statewide proposal.

Whether for good or for bad in the long run, this whole experience has shown that *you can fight City Hall*. A.K.

Another Swipe at Voluntarism

The Congress, in its wisdom, passed the Older Americans Act Amendments of 1978, which, among other provisions, created a federal meals-on-wheels program. Analysis of this new program leads one to recognize that the federal government believes its dollars and another costly bureaucracy are better than an experienced working program based on *voluntarism* at the local level.

Meals-on-wheels programs have functioned in this country for over twenty-five years. Balzano, in a careful analysis of the subject, pointed out that "hundreds, perhaps thousands (of such programs) have sprung up in response to an ever-rising demand for service. Most of these private neighborhood meals-on-wheels programs have relied almost ex-

clusively on volunteers to organize the program and deliver the meals to the homes of the elderly, and on charitable institutions—churches, civic organizations, the United Way—to subsidize recipients who are unable to pay for their meals."*

Despite the fact that local grass-roots organizations have the capability, experience, and desire to administer meals-on-wheels programs, the "feds" choose to bypass them and set up an expensive, duplicative, and undermining program.

As pointed out in the preceding editorial, *voluntarism* helped build the United States, but the bureaucrats seem intent on destroying it.

Balzano touched the heart of the matter: "In most cases common sense and the desire to help one's neighbor are all that are necessary. One does not need a master's degree in social work or gerontology to dish out chow at a nutrition center."*

Three cheers for Balzano and voluntarism!

A.K.

*Balzano, MP: *Federalizing Meals on Wheels: Private Sector Loss or Gain?* Washington, DC, American Enterprise Institute for Public Policy Research, 1979.

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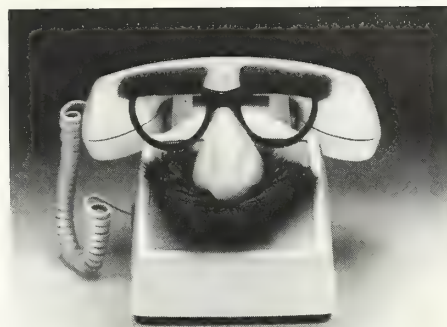
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Desquamative Interstitial Pneumonia (DIP)*

JOSEPH W. SOKOLOWSKI, JR., M.D. and
WILLIAM V. HARRER, M.D., Camden

Desquamative interstitial pneumonia (DIP) is characterized by the distinctive histologic feature of intraalveolar macrophages in association with radiographic evidence of lower lung zone infiltrates. The physiologic response is a restrictive ventilatory defect. A favorable outcome may be anticipated with corticosteroid therapy.

Hamman and Rich in 1935 described a respiratory disorder with features of interstitial fibrosis and rapidly progressive pulmonary hypertension. In the intervening years other interstitial disorders have been described with varying histologic and clinical patterns. Desquamative interstitial pneumonia (DIP) is unique among these interstitial diseases by virtue of its extensive investigations.

CLINICAL DESCRIPTION

Desquamative interstitial pneumonia (DIP) usually appears between the fourth and fifth decades with 60 percent of patients being male. Ten percent of the cases have been described in children, the youngest being two-and-a-half weeks.¹ Symptoms and clinical signs include non-productive cough, dyspnea, chest pain, weight loss, cyanosis, and clubbing. The classical roentgenographic findings are triangular shadows radiating from the hilar area into the lower lung zones with sparing of the costophrenic sulci.² However, this seems to be the exception rather than the rule. (figure 1). Occasionally, DIP may present as a localized nodular lesion.³ Rarely, the chest roentgenogram may be normal.⁴ Complications include pleural effusion or spontaneous pneumothorax.

PHYSIOLOGY

Physiological observations are represented by an increase in the alveolar-arterial gradient $P(A-a)O$ for oxygen as the principal and earliest manifestation. However, in contrast to

interstitial fibrosis of the lung, it may be either normal or reduced with exercise. Later changes include a reduction in the vital capacity reflecting a restrictive ventilatory defect as well as a decrease in pulmonary compliance. The most useful physiologic studies for evaluation of the course of the disease and its possible response to therapy are the $P(A-a)O$ and the single-breath diffusion capacity for carbon monoxide.⁵

DIAGNOSTIC STUDIES

Transbronchial lung biopsy is felt to be inadequate for the differentiation of interstitial fibrosis from desquamative interstitial pneumonia in regard to the extent of fibrosis and consequent projected response to therapy. Thoracotomy with open lung biopsy is indicated for the diagnosis of all interstitial pneumonias except where extensive honeycombing is present.⁵

PATHOLOGY

Desquamative interstitial pneumonia (DIP) originally was described by Liebow, Steer, and Billingsley in 1965.⁶ They presented a series of 18 patients with an interstitial pneumonia characterized by distinctive features on lung biopsy.

*From the Division of Pulmonary Medicine and Department of Pathology, Our Lady of Lourdes Hospital, Camden, New Jersey. This originally was presented as a scientific exhibit at the 211th Annual Meeting of the Medical Society of New Jersey, Atlantic City, New Jersey May 14-16, 1977. Correspondence may be addressed to Dr. Sokolowski, 501 Haddon Avenue, Haddonfield, New Jersey 08033.



Figure 1—Bibasilar interstitial infiltrate with obliteration of costophrenic sulci.

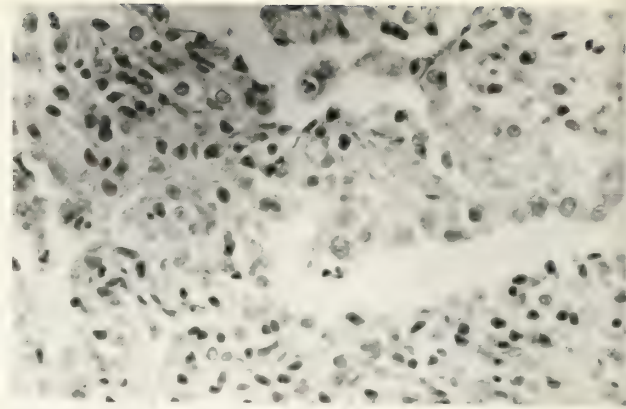


Figure 2—Desquamation of macrophages within air spaces.

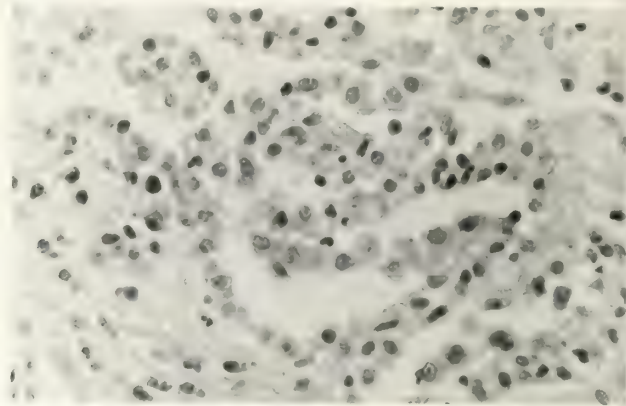


Figure 3—Interstitial infiltrate with minimal fibrosis.

These include an extensive desquamation of cells of the linings of the alveolar spaces and ducts into the alveoli (figure 2), minimal interstitial fibrosis (figure 3), lymphoid follicles, a uniformity of the histologic features throughout the biopsy specimen, and the absence of necrosis, hemorrhagic exudate, or hyaline membranes. The large mononuclear cells that fill the air spaces frequently assume a polygonal shape, like pavement stones. Originally it was thought that the majority of the intra-alveolar cells were Type II cells or granular pneumocytes. Evidence from electron microscopy indicates that the majority of the intra-alveolar cells are macrophages.⁷ However, the littoral cells are granular pneumocytes. The desquamative cells are PAS-positive and contain brown pigment that is not hemosiderin.

Scadding and Hinson expressed the opinion that desquamative interstitial pneumonia (DIP) represented an early stage of pulmonary fibrosis, and consequently declined to accept DIP as a distinct interstitial pneumonia.⁸ Subsequent investigators have supported this concept interpreting DIP and interstitial fibrosis as different stages of the same disease. Their conclusions are based on similarities in morphology, a mixed histologic pattern in some cases, and occasional progression to honeycombing in desquamative interstitial pneumonia.⁹

ETIOLOGY

There has been an association of desquamative interstitial pneumonia with other entities including a variety of dust exposures: asbestos, silica, graphite, talc, and tungsten carbide.¹⁰ In one instance, chronic nitrofurantoin therapy has been associated with the evolution of DIP.¹¹ The etiology of desquamative interstitial pneumonia remains obscure. It has been interpreted variously as a hypersensitivity disorder,

a viral infection, or possibly a non-specific response to a variety of inhalants. The intravenous administration of Freund's adjuvant in the rabbit produces similar histologic changes to those of desquamative interstitial pneumonia.¹² Pre-treatment with corticosteroids is preventive. The presence of intranuclear inclusions has raised the possibility of a viral etiology for desquamative interstitial pneumonia. However, these particles do not appear to be specific for DIP and probably do not represent viral particles.¹³

There is an association with collagen vascular disorders, rheumatoid arthritis, chronic discoid lupus, as well as a non-specific arthritis and hepatitis.¹⁴ Serologic investigations for circulating antibodies have revealed positive reactions for lupus cells, antinuclear factor, and latex flocculation. These findings are consistent with the proposition that DIP may present as the pulmonary abnormality in an immunologically mediated systemic disorder. Circulating immune complexes have been found in the serum of patients with chronic interstitial pneumonia. These immune complexes correlate with the deposition of immunoglobulin and complement in alveolar walls and capillaries.¹⁵ They may be considered an indicator of potential steroid responsiveness. Theoretically, a variety of stimuli may evoke the formation of circulating immune complexes and autoantibodies. The latter are deposited under the influence of the former in the interstitium and capillaries. The deposition of complement-containing complexes in the pulmonary parenchyma elicits a granulocyte mediated digestion of lung tissue which may evolve from a cellular phase into interstitial fibrosis.

TREATMENT AND PROGNOSIS

The prognosis for desquamative interstitial pneumonia is much more favorable than with the usual interstitial pneu-

monia, (UIP). A high mortality rate has been described in infancy. Spontaneous resolution has been described.¹⁶ Uncorrected mortality rates over a 10-year period approximate 16 percent. A distinct negative correlation exists with the presence of fibrosis.¹⁷ In those instances where it may be indicated, immuno-suppressive therapy, either corticosteroids or cytotoxic agents, may be employed. This results in a favorable response in 86 percent of the patients.¹⁸ Chemotherapy is initiated with a dosage of prednisone of 40 to 80 mg. per day with a reduction over a period of several weeks to 20 mg. In some instances, desquamative interstitial pneumonia will progress unaltered with or without the benefit of therapy to interstitial pulmonary fibrosis.¹⁹ The association of desquamative interstitial pneumonia with malignancy remains conjectural.²⁰ Presumably the association of DIP and malignancy evolves from atypical changes in either alveolar or bronchiolar epithelium of the "end-stage" lung of pulmonary fibrosis.

SUMMARY

Desquamative interstitial pneumonia most commonly appears between the fourth and fifth decades with radiographic evidence of lower lung zone infiltrates. Physiologic alterations are represented by an increase in the alveolar-arterial gradient for oxygen and the development of a restrictive ventilatory defect. An open-lung biopsy, the preferred diagnostic procedure, reveals the distinctive features of extensive desquamation of macrophages within the terminal air spaces.

From a pathologic viewpoint, DIP and interstitial fibrosis may represent different stages of the same disorder. The etiology of DIP has been variously attributed to infection, a non-specific response to inhalants, and a hypersensitivity mechanism. The prognosis remains favorable particularly with the influence of corticosteroid therapy.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug dosage should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahiolu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Treatment of Alcoholism in a General Hospital

LAURENCE R. MUNDY, M.D., Denville*

The development of a treatment program for alcoholics in a 260-bed general hospital is described. It started on a small scale, which included both detoxification and therapy aimed at teaching the patient how to deal with his addiction. How it expanded and developed in response to the needs of the community, local industries, and to the enthusiasm of the staff and the local Alcoholics Anonymous (A.A.) group are described. Eventually a comprehensive system of pre-admission counseling, family counseling, and a two-year aftercare program were developed. Relationships with industry, A.A., and other social services are described.

Most papers dealing with the treatment of alcoholism in general hospitals confine themselves largely to detoxification, a relatively simple matter in most cases, with perhaps some passing reference to referral to Alcoholics Anonymous (A.A.), counseling, or more definitive treatment. The purpose of this paper is to show how a very intensive and comprehensive treatment program developed in a hospital of moderate size, in good part in response to persistent demands from the community.

St. Clare's is a 262-bed general hospital serving a community in North Jersey, 35 miles west of the George Washington Bridge. The area contains heavy and light industry, dormitory suburbs, and even rural and farming country. The hospital was founded twenty-five years ago by the Sisters of the Sorrowful Mother to serve this community which at the time had no hospital. Currently it is administered by a mixed religious and lay board. In order to meet more effectively the needs of the community, advisory councils consisting of representatives of local residents and local industries were formed. In 1972 it was recommended by St. Clare's Industrial Advisory Council that the year 1973 be devoted to assessing the need for mental health and alcoholism services. A team consisting of a psychiatrist and two alcoholism counselors was retained under the direction of a mental health administrator to develop a small inpatient program for treating alcoholics. The program was to be housed in part of a floor known as the "Self-Care Unit." This floor had

been the residence of the nursing sisters and consisted of a single nursing station, dining room, and sixteen small, single, furnished rooms in which ambulatory patients could be accommodated.

The program opened on March 3, 1975. At first it consisted of detoxification, a brief introduction to the psychology of alcoholism and recovery, and a very firm introduction to Alcoholics Anonymous with aid from the local A.A. group which already had established weekly meetings in the hospital cafeteria.

From the first week the lectures and discussion groups achieved such an immediate popularity that we virtually were forced to extend the psychological treatment period to three weeks. The patients were detoxified on the medical floors to which they were admitted under exactly the same arrangements as any other sick patient and as soon as this was accomplished they were transferred to the Self-Care Unit.

At first, naturally enough, there was considerable apprehension on the part of the nursing staff and there were some contretemps. These occasionally were amusing, as when a still rather confused patient left the hospital in the middle of the night and was found wading in the Rockaway River, which fortunately is shallow. When complications were serious we received inestimable assistance from the

*Dr. Mundy is Medical Director, Alcoholism Treatment Services, Saint Clare's Hospital/Community Mental Health Center, Denville, New Jersey. He may be addressed at the hospital, Pocono Road, Denville 07834.

departments of medicine and surgery and that continues to this day. Naturally many of our patients who had been severe alcoholics for many years suffered from a wide range of medical and surgical disorders which frequently required urgent treatment. Many patients were admitted *via* the emergency room to which they were brought by the police, A.A. members, and their families. In some ways this was a discouraging process as their motivation was minimal and, as soon as they had been partially detoxified, most of them left against medical advice. For this reason we prefer to treat such patients in the emergency room and to ask them to call back for admission to the Alcohol Treatment Services program during the daytime when we can attempt to develop their motivation to stay for the whole program.

The attitude of the nursing staff changed rapidly from apprehension to intense interest when they saw how acutely ill alcoholic patients responded to good medical and nursing care, empathy, and a positive treatment program. By this time, the definitive treatment program had been extended to three weeks, which is the maximum period covered by most health insurance policies, for intensive treatment. The vast majority of our patients were wage-earning and salaried people who could not stay in a program that extended beyond their insurance coverage. They were now receiving five information-packed lectures weekly in the mornings, group therapy, and discussion groups every afternoon, and movies and A.A. meetings in the evenings.^a The open A.A. meeting conducted by our local group one evening weekly had become immensely popular. Patients' families attended regularly; usually over two hundred people were present. Recently discharged patients themselves formed an alumni group and combined closed A.A. discussion groups for patients and ex-patients were held every Saturday and Sunday.

During the first year two hundred and fifty-seven patients were treated and between March 3, 1975 and June 1, 1977, when the entire inpatient program was moved to another floor, a total of six hundred and four patients were treated in the Self-Care Unit. The increasing presence of families at our open meetings, the formation of Al-Anon and Ala-Teen groups, gave rise to pressure for family counseling. Accordingly, we started a group family counseling service which has been extremely popular and helpful ever since. At this time it also became obvious that a good deal of our success would depend on adequate follow-up. In cooperation with referring industries, who were by now developing their own alcoholism programs, we developed a highly organized group therapy program for ex-patients which extended over a period of two years—indeed, for as long as an interested patient felt the need for more help. Patients expressed their needs in such a way that the program naturally divided itself into two groups, one of which was for patients who had been out of the hospital for less than three months. Their anxieties were largely focused on staying sober in a drinking world. Those beyond the ninety-day period were now more focused on family life, their work situation, and problems of growth and development. Both of these groups continue and thrive today.

On June 1, 1977 the inpatient program was moved up a floor to redesigned and rebuilt premises where we now have a small, but comfortable convenient and well-organized unit. This consists of two rooms containing one bed each close to the nurses' station for detoxification and fourteen beds for

patients taking part in the psychotherapy program. The rest of the unit also contains a therapy room, cafeteria, lounge, and offices for the expanded staff which has grown from the original three to a total of six clinicians responsible for outpatient counseling, individual and group family counseling, and liaison with local industries and social agencies.

As our program became more widely known our ties with local industries, churches, and community action groups strengthened and we developed a solid relationship with industrial alcoholism programs and Alcoholics Anonymous. This relationship with industry in its turn has led to the formation of an individual outpatient counseling program incorporating alcoholism, chemical dependency, and problems of family and resettlement relationships on an individual basis for victims, their spouses, married couples, and families.

Our relationships with the local police and the hospital emergency service are cordial and constructive, but require further development. We need a holding room in which acutely intoxicated people can be allowed time to sober up under observation and to make a more definitive diagnosis as to the presence of medical or surgical complications. Many of these patients are admitted to the hospital under the care of members of the departments of medicine and surgery for the treatment of such acute conditions. As of December 31, 1978, 1118 patients have been treated. We know that 65 percent of these patients regularly attend local A.A. meetings and our Aftercare Program.

Our activity program is an extremely busy one and, in the opinion of this writer, it well could be extended over a four-week period. We do, however, feel able to offer the chemically dependent person and his or her family very comprehensive treatment before, during, and after hospital admission. The active ingredients are the thorough medical work-up, the intensive education and psychotherapy, early involvement in Alcoholics Anonymous with a tie-in immediately after the patient leaves the hospital, involvement of the family in therapy, and intensive follow-up. These ingredients make the program effective, particularly the highly structured aftercare and our close relationship with industrial alcoholism programs. The program has aroused intense enthusiasm and involvement on the part of all those who work in it, including local A.A. members, who see the dramatic changes that take place in the patients after two weeks in the hospital. Contrariwise it is the enthusiasm and emotional involvement of the staff to which the patients especially respond.

Our most responsive patients have been those who have achieved sufficient maturity to established positions of responsibility, those who have jobs and families, and a stake in the community. These patients very easily see the happiness that can be achieved through sobriety and are willing to work for it. Although we have seen many wonderful recoveries among young people, it is those who are immature, unmotivated, and have not yet established a firm sense of social responsibility who present our most difficult challenge. Indeed recognition, often very painful, that he is a good way down a disastrous road is a major factor in making a patient ready for treatment.

If there is a single unique feature, it is above all the way the program was developed in response to a community need, the way in which the need itself virtually forced the program to expand and develop, producing a reciprocal enthusiasm and dedication involving staff, patients, and community. If there is one overall need it is to maintain patient involvement

^aContent details may be obtained from the author.

for the long haul. For this a solid aftercare program, comprehensive family services, and close involvement with A.A., industry, and community services is essential.

SUMMARY

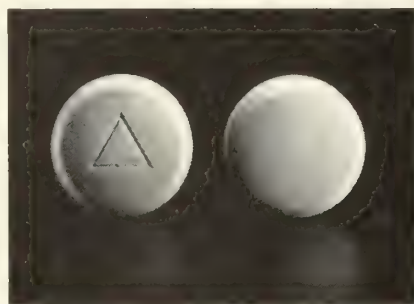
A small inpatient program for the treatment of alcoholism was developed in 1975 in St. Clare's Hospital, Denville, a 260-bed general hospital in North Jersey. The program rapidly developed into a comprehensive medical detoxification system integrated with a three-week program of didactic lectures, group psychotherapy, and A.A. meetings. This was supplemented by individual counseling and before long, in good part at the request of local industries and agencies, a two-year aftercare group-therapy program was organized. The needs of the patients and their families quite naturally

led to a family counseling program coupled with Al-Anon meetings followed by a pre-admission program for those closely involved with alcoholics who were still drinking and patients who desired help, but for various reasons were not ready to enter the inpatient program. In due course, the entire program was moved to a specially designed hospital unit. Though still small, it offered greatly improved accommodation and a better integrated program. The patients became very involved with the local A.A. group which meets regularly in the hospital; many of them have become active movers and shakers in the A.A. fellowship. Each aspect of the program has made its own contribution to its overall success. This program is described as one which obviously has met an intense and widespread need and one which could be developed in any medium-sized hospital.

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.



Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

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MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

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A Study of Patient Waiting Times in a Moderate-Sized Teaching Hospital

JAMES D. FOSTER, M.P.A. and
DONALD B. LOURIA, M.D., Newark

A series of studies on waiting time and patient attitudes was carried out in the outpatient department of a moderate-sized municipal hospital in Newark, New Jersey. On the basis of these and other studies, we suggest that waiting time be monitored with a goal of a maximum 30-minute waiting time. This simple expedient markedly would increase patient satisfaction with the municipal hospitals that for most of the patients serve as primary care facilities.

Martland Hospital is one of five major hospitals serving Newark, New Jersey, a city with a population of 366,000 (54 percent black, 39 percent white, and the remaining Hispanic) and like most large cities in the United States today, a community with many health problems. Until 1968, Martland was the City's municipal hospital, primarily serving the poor and medically indigent.

The facility has 600 beds, admits approximately 50 patients per day and has outpatient (OPD) and emergency units that serve approximately 86,000 and 76,000 patients respectively per year.¹ In 1968, the hospital was acquired by the State of New Jersey and became the teaching hospital for the Newark campus of the College of Medicine and Dentistry of New Jersey.

To investigate the continuous and often acerbic complaints about the hospital in past years, the Department of Preventive Medicine and Community Health, New Jersey Medical School conducted a series of small surveys over a seven-year period to assess waiting periods and patient satisfaction for those persons seeking medical care in the hospital's outpatient department. We focused on waiting time because this was thought to be a major problem.

PROCEDURE AND RESULTS

During each study period every third patient entering the OPD was asked to participate. Patients arriving late for their appointments and walk-ins were not included.

The interviews were conducted by individuals recruited from the community. Those conducting the interviews were given a two-day orientation which included interview techniques, explanation of the study, and emphasis on the need for sensitivity in approaching the prospective participants.

The OPD was chosen because it was from this area that most of the complaints originated. Patients were requested to participate after they had reported to the outpatient registration desk and the questionnaire was administered in the OPD reception area while they were waiting for treatment.

Patients' waiting times were monitored in the following manner: each was given a 3 x 5 index card and the time of appointment, time of arrival, time called for service, and time released were recorded on the card by the interviewers stationed at specific locations in the OPD as the patient progressed through those phases. Patients coming to the OPD generally have prearranged appointments, usually given to them when they were seen at an earlier time in the emergency room, the primary referral source for OPD patients. In all the studies the overwhelming majority of the patients were black and had been attending the OPD for more than six months.

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The first assessment of patient waiting time was done in September, 1970, shortly after the new outpatient wing of the Martland Hospital was completed. During the ten days the study was conducted, approximately 1,000 of the 1,500 receiving care were polled. Half the patients waited one hour or more, and the average wait was 80 minutes from time of appointment to the time seen by a physician.

In December 1973, 280 patients studied over a one-week period had an average wait of 68 minutes, 61 percent waiting over one hour.

In January 1976, a study of 100 patients was done. The average waiting time was 52 minutes, a substantial reduction from the 80 minutes observed five and a half years earlier but the proportion waiting over one hour was 52 percent, this percentage being virtually identical to that observed in the first study. (Table 1).

Patients then were asked to list the changes they wished to see at the Martland Hospital. Faster service dwarfed all other suggestions. This was equally true in the first survey of this type in 1973, and in a follow-up survey in 1976. (Table 2).

To determine whether the complaint of excessive waiting time related to duration of waiting on a given day we surveyed 200 patients in the OPD in June, 1977. The patient group interviewed was similar to those questioned in previous surveys. They were asked to list the three major changes they wished to see in the Martland Hospital. One hundred of the patients had been waiting for 20 to 50 minutes at the time of interview while the other one hundred had been waiting for at least 70 minutes, in some cases more than 120 minutes. Overwhelmingly the major suggestion for both groups was faster service. This was the first choice of 81 percent of those waiting less than an hour and 80 percent of those waiting more than 60 minutes. The second and third choices for both groups were an appointment system and better services. Thus, the request for faster services did not seem to depend on the duration of waiting at the time of interview.

We then examined the relationship between duration of waiting time and patient perceptions of the quality of care, their feelings about staff attitudes, and their choice of medical facilities. No relationship was noted between waiting time on a given day and patient views about quality of care. Even those waiting longer usually felt the staff was interested, the care was good, and Martland was the hospital of choice. (Tables 3-4).

DISCUSSION

In 1970, the mean waiting time between appointment and initiation of physician services was 80 minutes. In 1976, the average waiting period had fallen to 52 minutes, a 35 percent drop, but the proportion waiting at least one hour had not changed at all; over half the patients waited at least 60 minutes. The reduction in mean waiting time appears to have resulted from several factors, these including additional OPD personnel (both medical and ancillary), extension of clinic hours, and reduction in clinic patient load. Since the early 1970's, more have been added to the house staff and they have been scheduled more effectively. Intake personnel has more than doubled, thus expediting patient flow. Clinic hours have been extended by one hour so that patient appointments can be stretched out over a longer period. Finally, with the expanded use of Medicaid and Medicare, many patients have chosen to seek medical care elsewhere in the City at a facility closer to their homes. Before the availability of Medicaid and Medicare, medical indigents in Newark had only one facility to attend since the other city hospitals were reluctant to serve them. Prior to 1970, Martland's OPD treated at least 100,000 patients annually. Since 1970, the number of OPD visits has dropped; in 1976, there were approximately 76,000 outpatient visits, almost a 25 percent drop over a six-year period. Although average waiting times fell, the fact that more than half the patients

Table 1
Martland Hospital Patient Waiting Time
Between Appointment Time and Time Seen
in Outpatient Department

Year	Average Time (min.)	Percent Waiting Over 60 Minutes
1970	80	50.6
1973	68	61
1976	52	52

Table 2
Changes Patients Would Like To See In Martland's
Outpatient Department Services

Choice	1973		1976	
	No.	%	No.	%
Faster service	115	73	59	67
Better service	5	3	6	7
Nurses' attitude	10	6	2	2
Cleaner facility	1	1	2	2
Larger waiting room	2	1		
Same MD each time	17	11	6	7
Change in fee	3	2	2	2
Everything	5	3	11	13
Total	158	100	88	100

Table 3
The Relationship Between Patients' Waiting Time
and Their Perception of Quality of Patient Care

Waiting in Hours	Excellent		Good		Fair		Poor		No Answer		TOTAL
	No.	%	No.	%	No.	%	No.	%	No.	%	
< 1	1	5	18	85	2	10	0	0	0	0	21
1 - < 2	7	18	23	56	9	22	1	2	1	2	41
2 - < 3	6	24	15	60	1	4	2	8	1	4	25
3 - < 4	1	ts*	4	ts*	1	ts*	0	0	0	0	6
4 - < 5	1	ts*	1	ts*	0	0	0	0	0	0	2
5 and more	1	ts*	4	ts*	1	ts*	0	0	0	0	6

*ts too small a number to show percentage

Table 4
Patient Waiting Time and Choice of Facilities—
Martland Patients, 1976

Waiting in Hours	Martland		Aff. Hospital		Non-Aff. Hospital		Private Physicians		Total
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	
< 1	19	90	1	5	1	5	0	0	21
1 – < 2	29	72	6	15	4	10	1	3	40
2 – < 3	20	80	2	8	1	4	2	8	25
3 – < 4	4	ts*	2	ts*	0	0	0	0	6
4 – < 5	2	ts*	0	0	0	0	0	0	2
5 & more	5	ts*	1	ts*	0	0	0	0	6

Aff. = medical school affiliated hospital

*ts too small a number to show percentage

waited over one hour is distressing.

It is interesting that despite the long waits, patients generally felt care was good, the staff was interested, and they named the Martland as their medical facility of choice.

The waiting times we observed are quite similar to those reported in other studies. In the classic Nuffield study in England in 1952, the average waiting time was 56 minutes, and in 18 of 34 clinics studied mean waiting time exceeded one hour.²

In the second Nuffield study carried out in 1963 after vigorous governmental efforts to improve patient scheduling and physician punctuality, mean waiting time fell to 25 minutes.³ Nevertheless, in two of 60 clinic units, average waiting time exceeded 40 minutes and 11.5 percent of the total sample waited more than one hour.

Rockart and Hoffman reported in 1968, that 55 percent of patients in the outpatient department waited over one hour to see a physician.⁴ Villegas studied waiting times at the Hennepin General Hospital in Minneapolis and found that with the existing system, 20 to 50 percent of patients were seen within 30 minutes, but the average waiting time ranged from 58 to 70 minutes.⁵

In part, the excessive waiting times have been ascribed to physician tardiness, but for the most part, blame has been focused on the block appointment system.⁵ Badgley and Furnal point out that patients frequently break their appointments and it is often for this reason that many patients are scheduled for the same time.⁶

Villegas found that with more intelligent scheduling patterns, average waiting time was reduced in the best outpatient experimental models to 31 minutes, 49 percent being seen by a physician within 30 minutes.⁵ Rockart and Hoffman noted that waiting time related in part to the physician's feelings of responsibility for individual patients. With block assignments, average waiting time was 85 minutes. When patients were assigned to individual physicians within the block assignment, mean waiting time fell to 55 minutes. Both physicians and patients were more likely to be on time in a system in which the patient felt individual care was being given and the physician felt responsibilities toward specific patients. Waiting time fell further to 33 minutes with individual scheduling rather than block assignment.⁴

Despite general agreement that block assignment is undesirable and that inordinate waiting times are intolerable, there is no evidence that the situation has changed in most hospitals in the last two decades. Computerized appointment reminders are a possible way to increase patient punctuality. Each patient visit should be computerized and reminders printed out in letter form and mailed four or five working

days before the patient's visit. Gates and Colborn found that 83 percent of those patients receiving a letter reminder kept their appointment as compared to only 55 percent of those who did not receive a reminder.⁷

Our findings might appear to be entirely predictable and our conclusions merely reiteration of what is already known but we were surprised to find the extent to which waiting time dwarfed all other complaints. If this is the major criticism by the patient, then it is obviously the duty of physicians and administrators to do something about it. Indeed, it is surprising that the medical profession has not made reduction in waiting times a major priority during the last three decades. It seems likely that if faster services were provided, patient satisfaction with the health care system would increase precipitously. A goal of maximum individual wait of 30 minutes is not outlandish. This recommendation is similar to the proposal of Millward made in 1955 that 50 percent of patients be seen within 15 minutes, 75 percent by 30 minutes, and at least 97 percent by one hour.⁸

It would seem a simple procedure to stamp every chart with arrival time and time seen by the physician. If any patient waits for over one hour, the chart should be reviewed by an appropriate OPD committee and the causes should be remedied. Once this is carried out effectively for those waiting over one hour it should then be done in each case with more than a 45 minute wait.

The assessment of waiting times and the mandate to move toward a maximum wait of 30 minutes also would encourage the use of more imaginative scheduling systems and would compel the physicians to reduce their own tardiness. By removing the major cause of dissatisfaction, it would make the hospital outpatient department a far more positive experience for the millions of persons accustomed to using such facilities for their primary medical care.

SUMMARY

A series of studies on waiting time and patient attitudes was carried out in the outpatient department of a moderate-sized municipal hospital in Newark, New Jersey.

Initially, mean waiting time was 80 minutes, and this fell during the study period to 52 minutes, but the percentage of patients waiting over one hour (about 50 percent) did not change. This inordinately long waiting time was reflected in the finding that the complaint of slow service dwarfed all others. The complaint about time of services was unrelated to the specific duration of waiting on the day the questionnaire was administered.

On the basis of these and other studies, we suggest that

waiting time be monitored with a goal of a maximum 30 minute waiting time. This simple expedient markedly would increase patient satisfaction with the municipal hospitals that for most of the patients serve as primary care facilities.

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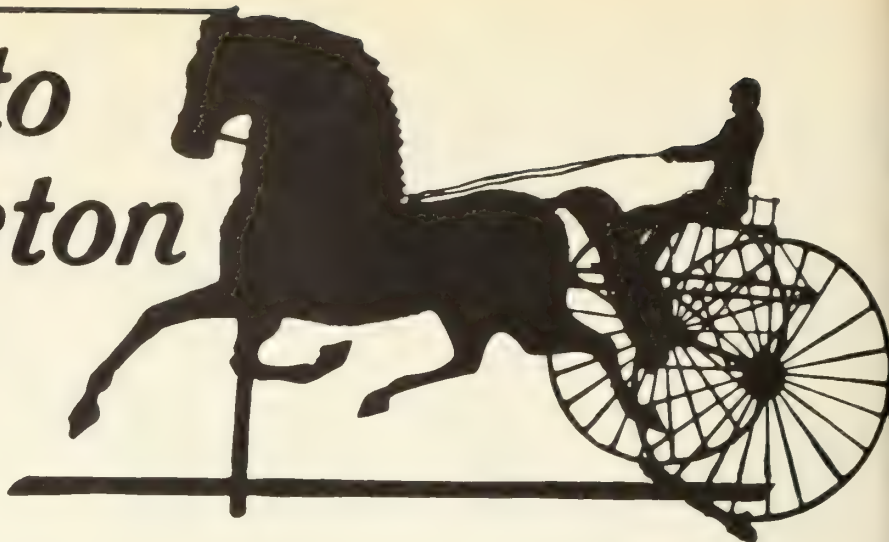
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Diverticulosis of the Vermiform Appendix

RICHARD J. D'AMICO, M.D., Bayonne*

Diverticulosis of the vermiform appendix is an infrequent, but interesting problem. Previous articles in the surgical literature have described appendicular diverticulosis as a predisposing factor to perforated appendicitis. Prophylactic appendectomy should be performed, if the condition is shown radiographically.

The incidence of diverticulosis of the appendix varies from 0.08 percent to 2.80 percent.¹ Multiple diverticula are less frequent than a solitary diverticulum. The lesion frequently is not demonstrated radiographically, therefore, the diagnosis of non-infected diverticula of the appendix is very rare.

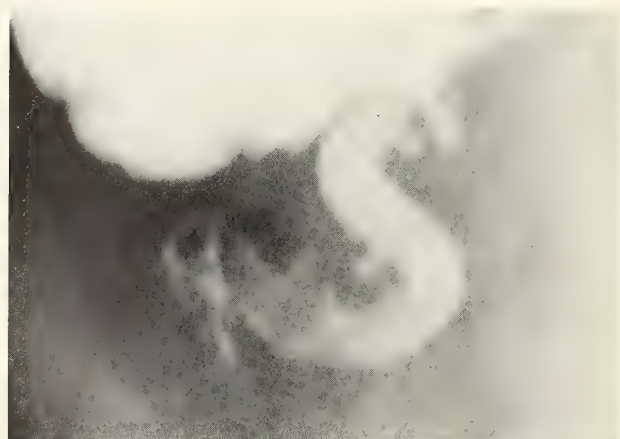
CASE REPORT

A 57-year-old man was referred as an outpatient to the Bayonne Hospital radiology department for a barium enema x-ray. He had complained of "vague abdominal pain." The study revealed diverticulosis of the appendix (Figure). The patient did not have surgery and follow-up almost a year later disclosed that he was asymptomatic.

Detailed reports in the literature have discussed the possible etiology of appendicular diverticulosis.²⁻⁴ Therefore, a discussion of the etiology and kinds of diverticula is not essential in this report.

If the diverticulæ do become inflamed, the presenting signs and symptoms may include a mass in the right iliac fossa or tenderness in the right lower quadrant consistent with the diagnosis of acute appendicitis. Some patients with this problem have complained of vague abdominal symptoms for many years. It should be noted, however, that patients with appendicular diverticulitis are older than those patients who have acute appendicitis.⁵

When a diverticulum does become infected, the signs and



Figure—Radiographic spot film of the barium-filled cecum and appendix, showing multiple diverticula of the appendix.

symptoms are those usually associated with acute appendicitis. The clinical course is similar to that of acute appendicitis, although perforation may occur earlier.

Surgeons must be alert to possible complications of diverticulosis of the appendix. When diverticulitis does develop as a complication of diverticulosis, recognition of the lesion as

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an inflammatory mass may be difficult. If diverticulitis should complicate the disease, it might be impossible to distinguish from neoplasm. A mistaken diagnosis at surgery may lead to a more radical procedure than is necessary.

SUMMARY

Diverticulosis of the appendix may be recognized incidentally during the course of a barium enema examination or during the course of a surgical procedure. Surgical removal would seem to be a rational conclusion based on the potential development of complications and the danger of early perforation.^{6,7}

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Convulsive Seizures Due to Phenylpropanolamine

PAULINO D. DEOCAMPO, M.D., Holmdel*

Phenylpropanolamine has been used as a nasal decongestant and anorexiant. This case report and review of the literature shows its potential for life-threatening adverse effects. It is suggested that the use of this drug should be by physician's prescription only.

Convulsive seizures are known to have many causes. Drug reaction, either as overdosage or as a side effect, has been implicated with many drugs, including adrenergic agents. Phenylpropanolamine (PPA) is an amphetamine-related drug, widely used as a nasal decongestant and often combined with antihistamine. It also has been used in combination with caffeine and vitamin-formulation in the treatment of exogenous obesity. Moreover, these preparations are available over the counter without a physician's prescription. This report concerns a patient who had convulsive seizures following ingestion of PPA vitamin formulation.

CASE REPORT

The patient was a 44-year-old housewife, seen in the emergency room because of sudden onset of severe headache, blurred vision followed by transient loss of vision, and accompanied by "cold, clammy sweats." One hour prior to admission the patient took Diadax^{®a} for obesity, as recommended by a friend. Shortly after her arrival in the emergency room she had a grand mal seizure. In the past, she had recurrent generalized headaches, relieved by acetaminophen. At age five she experienced a convulsive seizure after taking a "cold medication." Her mother died of a ruptured berry aneurysm at age forty.

The physical examination revealed a well-developed, moderately obese Caucasian female, who was confused and disoriented. The blood pressure was 180/90. The calvarium

was normal. There was no carotid bruit. The pupils were equal. There was a mild right-gaze palsy. Corneal reflexes were present on both sides. The eye grounds were normal. The deep tendon reflexes were exaggerated bilaterally, without any Babinski toe sign. The rest of the physical findings were within physiological limits. The complete blood count, SMA-20, and urinalysis were normal. The chest x-rays, skull x-rays and electrocardiogram were likewise normal.

The hospital course was stormy. Three episodes of grand mal seizures developed in the ensuing four hours; each was terminated by intravenous diazepam. A tentative diagnosis of a rapidly progressive intracranial vascular lesion was made. A spinal fluid examination showed an opening pressure of over 250 mm. of water with grossly bloody fluid. Bilateral transcervical angiography was normal. Supportive medical measures were instituted, along with Dilantin[®] (phenytoin), 100 mgms. every six hours intravenously. This was followed by gradual improvement of the patient's neurological deficits. Subsequently a brain scan, computed tomography of the brain, and electroencephalogram all proved to be normal. The patient did not develop further seizures and on the sixth hospital day she was discharged as "recovered." She verified her ingestion of the Diadax^{®a} one

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^aDiadax[®]—O'Connor Products Company, Redford, Michigan.

and a half hours prior to the onset of the headaches.

COMMENTS

There seems little doubt that these convulsive seizures were related to the ingestion of Diadax[®]. This is an over-the-counter formulation containing 75 mgms. of PPA in sustained release granules. It also contains natural grapefruit extract, and vitamins C and E. It is used widely in the treatment of exogenous obesity. Studies show that in a wax matrix time-release preparation, 33 to 40 percent of the drug is released in the first hour and the rest is released in the next six to seven hours.¹ It is estimated that the patient absorbed 25 to 30 mgms. of phenylpropanolamine in the first hour after ingestion. This is not an unusual amount, inasmuch as dosage up to 50 mgms. every three hours has been used with side effects equal to or only slightly exceeding those of placebo: nervousness, insomnia, motor restlessness, and nausea.² Although the amount of the drug was not excessive, I believe that the patient was highly sensitive to the adrenergic effects as evidenced by her convulsion during childhood following ingestion of a "cold medication."

Most adrenergic drugs manifest systemic effects when given in excessive amounts. These drugs include topical nasal decongestants such as tetrahydrozoline and nafazoline. Such side effects are very common in children and infants, as well as in patients with cardiovascular disease and thyroid disease.³ These effects include hypertension, nervousness, nausea, dizziness, palpitation, and occasionally evidence of central nervous stimulation, such as convulsive seizures.

Phenylpropanolamine has been used widely as an effective and safe nasal decongestant and as an anorexiant.¹ It has been available without prescription in many proprietary formulations approved by the Food and Drug Administration.⁴ PPA overdose has been associated with marked hypertension (280/140) with sustained agitation and hallucinations, sustained diastolic hypertension, ventricular arrhythmia and hyperpyrexia with disseminated intravascular coagulation and death from myocardial and cerebral thrombosis.⁵ PPA has been incriminated in an adverse drug interaction with the beta adrenergic blocking agent, oxprenolol, and methyldopa.⁶ It was postulated that in this drug interaction the alpha adrenergic effect of phenylpropanolamine vasoconstriction was unopposed in

the presence of oxprenolol resulting in a sustained severe hypertension.

Search of the literature over the past eight years revealed no report of convulsive seizures secondary to PPA overdose or hypersensitivity reaction. Griboff *et al.* found no significant central nervous system stimulation in his study of PPA as an anorexiant.¹ He noted that reports of stimulation were anecdotal and only in the form of letters to the editor. This present case report and the adverse reactions mentioned previously show that the side effects may be severe and potentially fatal.

In view of these potentially dangerous side effects of PPA, alone or in combination, it is suggested that wider dissemination of this information be made. It is also suggested that PPA should be dispensed only by prescription, because of the widespread use of methyldopa and, most recently, beta adrenergic blocking agents such as propranolol and metoprolol tartrate.

SUMMARY

A case of a severe, life-threatening convulsive seizure following ingestion of phenylpropanolamine in sustained release form is reported. Adverse reactions to this drug are reviewed. It is suggested that phenylpropanolamine should be used by physician's prescription only.

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^aDiadax[®]—O'Connor Products Company, Redford, Michigan.

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Trisomy 21 with Translocation t(3p-;21q+)

THEODORE KUSHNICK, M.D.; BERNARD SEARLE, Ph.D.;
C. KICHA, B.A.; G. VASIOS, B.A., Newark*

An infant with the phenotype of Down's syndrome and unusual cytogenetic findings is described. The baby was trisomic for chromosome number 21 as a result of a maternally inherited balanced reciprocal translocation t(3p-;21q+) and an extra 21. Family studies revealed that the mother's rearrangement had occurred in *de novo* fashion.

There have been many reports concerning translocations involving chromosome 21 and other autosomes in Robertsonian and non-Robertsonian fashion¹⁻⁵. There have been fewer articles with regard to translocations involving chromosome 3 with the production of abnormal phenotypes due to partial trisomy or deletion of the long or short arm of that chromosome.⁶⁻⁹

Recently, there has been greater appreciation of the probability of an increased frequency of nondisjunction in families in which a phenotypically normal individual is carrying an atypical G or D chromosome.^{5,10,11} It is the purpose of this report to describe an infant with Down's syndrome phenotype who had the cytogenetic findings of a trisomic state for chromosome 21 with a maternally inherited balanced translocation involving the distal third of the short arm of one number 3 chromosome and the long arm of one number 21 chromosome t(3p-;21q+).

CASE REPORT

The product of a second full-term normal pregnancy and induced delivery was born on November 23, 1976. Birth weight was 2800 gms; length 47 cm; head circumference 33 cm. On the first day of life, when he was noted to have the physical stigmata of Down's syndrome with severe cyanotic congenital heart disease, the patient was transferred to United Hospitals Medical Center, Newark, for cardiac evaluation. The diagnosis of ventricular septal defect with

pulmonic stenosis without cardiac failure was made.

At age eight days, the patient was discharged with follow-up visits arranged for continued cardiac surveillance. The child subsequently was enrolled in the local infant stimulation program and was given a gradually expanded infant diet.

During his initial newborn evaluation, blood was drawn and sent to the Division of Human Genetics of the Department of Pediatrics at the New Jersey Medical School for cytogenetic studies. The results of this investigation demonstrated that the patient was trisomic for chromosome 21, with 47 chromosomes in each cell, but in addition, the patient had a partial deletion of the short arm of one number 3 chromosome (3p-) with that material reciprocally translocated to the long arm of one of the number 21 chromosomes (21q+) (see figure 1).

Because of the cytogenetic results, the patient was re-evaluated when he was five months of age. At that time, his physical examination revealed the typical findings of Down's

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Figure 1—Karyotype of patient demonstrating 47,XY t(3;21) (p21;q22)+21. Thus, the patient has trisomy 21 with reciprocal translocation between the short arm of one number 3 chromosome and long arm of one number 21 chromosome.



Figures 2 and 3—Frontal and lateral views of the patient demonstrating the phenotype of Down's syndrome.

syndrome (see figures 2 and 3) complicated by cyanotic congenital heart disease. Developmental level appeared compatible with the age of two and a half months.

Family history revealed the following pertinent data: lack of history of Down's syndrome, repeated miscarriages, and mental retardation in the mother's family which was composed of a fraternal twin brother, three other brothers, and one sister. The patient's father's history was significant only in that a first cousin had died of cystic fibrosis.

Cytogenetic studies on the patient's parents, siblings, maternal twin brother and maternal grandparents are reported below.

Subsequent development of the proband was extremely poor. His cardiac status gradually deteriorated despite digoxin therapy, and he expired in cardiac failure on June 10, 1978, at age one year, six and a half months.

CYTOGENETIC STUDIES

Peripheral blood cultures from the proband were incubated and harvested after three days. The cells were banded with 0.1 percent trypsin and stained with 4 percent Giemsa (Harleco) using a modification of an existing procedure.¹²

The banded karyotypes of the proband revealed trisomy 21 with translocation between the short arm of one number 3 chromosome and the long arm of one number 21

chromosome. The karyotype of the proband, therefore, had the following designation: 47,XY,del(3) (qter→p21:),t(3;21) (3pter→3p21::21q22→21pter),+21. This designation was derived from the banding patterns which were suggestive of breakage at the interface between the 3p21 and 3p22, with the remainder of the 3p attached to the band 21p22.

Subsequently, chromosome analysis on the proband's phenotypically normal mother revealed that she had a balanced carrier state for the same non-Robertsonian translocation. Karyotypes of the father, the patient's normal male sibling, maternal grandparents, and the maternal twin brother were all chromosomally normal with appropriate sex chromosome complements.

DISCUSSION

As demonstrated in figures 2 and 3, the patient had multiple physical stigmata of Down's syndrome associated with severe congenital heart disease. His cytogenetic studies revealed trisomy for number 21 chromosome material, but one of the number 21 chromosomes was involved with a balanced translocation of material from one number 3 chromosome (figure 1). The patient's phenotypically normal mother was a balanced translocation carrier t(3p-;21q+) (figure 4).

Studies on the remainder of the mother's family were

normal and indicated that this unusual translocation had occurred *de novo* in the propositus' mother.

Initially, this family was at risk for producing offspring with partial trisomy 3p syndrome,^{6,9} non-viable fetuses, possible deletion of 3p material,⁸ chromosomally normal offspring, or balanced translocation carriers similar to the mother.

Inasmuch as the translocation did involve a G chromosome, the patient's trisomic state for a number 21 chromosome would be compatible with the suggestion of others that an atypical G or D chromosome carrier state, such as this family's translocation, does cause increased risk for non-disjunction in such families.^{5,10,11}

Amniocentesis for cytogenetic studies has been recommended for future pregnancies in this family. Although this recommendation has been tempered to some extent by the knowledge that there is a statistically slightly increased incidence of mental retardation in *de novo* carriers of non-Robertsonian balanced rearrangements, such a situation has appeared less likely in *familial* rearrangements.¹³ In *de novo* situations, it has been suggested that the deleterious effect of an apparently balanced translocation may be due to small deletions or duplications, gene mutation, or detrimental effect from rearrangement of gene positions.

Inasmuch as the mother has the rearrangement, amniocentesis studies which demonstrate a fetal balanced reciprocal translocation in future pregnancies for this family would be in favor of the fetus being a normal carrier similar to the mother.

SUMMARY

An infant with Down's syndrome and severe congenital heart disease had cytogenetic studies which demonstrated trisomy 21. However, the long arm of one of the number 21 chromosomes was involved with a balanced translocation of material from the short arm of a number 3 chromosome. His phenotypically normal mother was a *de novo* balanced translocation carrier $t(3p-;21q+)$.

Initially, the family's risk for abnormal offspring would have seemed to be limited to partial 3 short arm trisomy or 3 short arm deletion. However, the child's trisomy 21 appears compatible with the suggestion of other workers that an atypical G or D chromosome, as in this familial translocation, increases the risk for non-disjunction and resultant trisomic states.

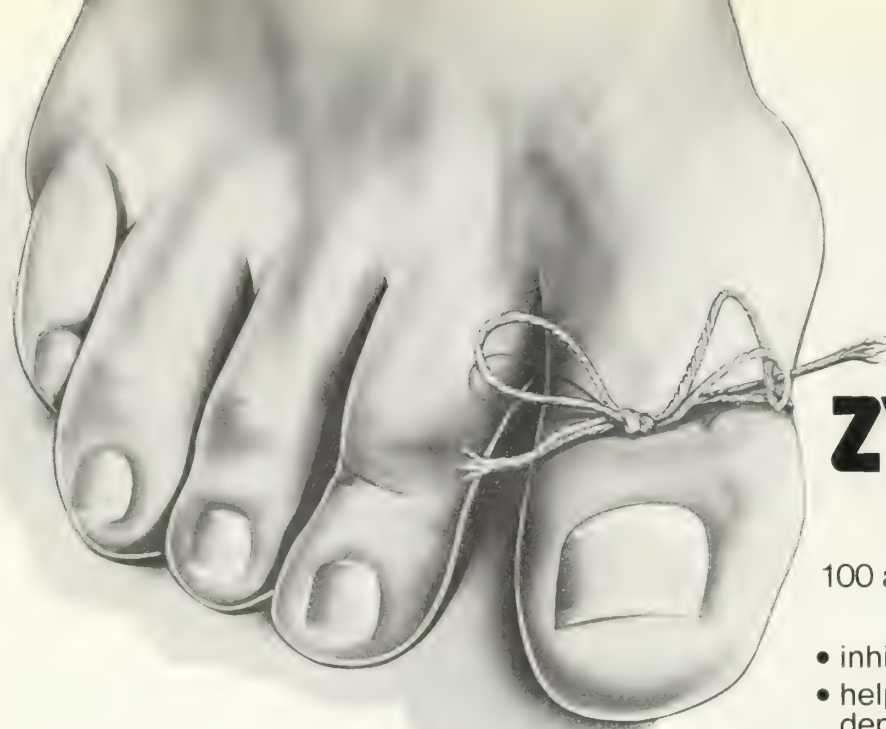
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4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age Zyloprim[®] (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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The Public Stake in Health Policy

ELI GINZBERG, Ph.D., New York

The history of the modern American health care system is reviewed. The author discusses the role of government, the influence of inflation, and the health care industry as a market system. Some potential improvements to the system are described.

Americans currently are spending about \$200 billion a year on the health care system. The huge expenditures for health care underscore the important stake that the public has in the output of this system and its responsiveness to their needs. By public I mean more than those people who have a primary interest and involvement in policy such as physicians, hospital administrators, or the heads of insurance companies. Clearly these individuals are heavily involved in the health care arena. However, the concern in health policy should be extended to include the population it is intended to serve. To appreciate the scale and scope of the health care system, I will review its evolution since WWI and, in this context, consider the major issues confronting us today and their implications for public policy.

MODERN HEALTH CARE SYSTEM

The modern health care system, as we know it, developed after World War I. At that time, the major financial burden of the system—usually the construction of the hospital and its operating deficit—was sustained by philanthropy. With the exception of a few county and municipal institutions, nonprofit institutions primarily were supported by community effort or the very rich. Yet even with this support, it was often better to stay out of the hospital than to go into one. It was after WWII that the push for improved health care became prevalent and access to health care has remained a national issue ever since.

The first major change in the system occurred during World War II. In a period of wage control, the trade unions successfully bargained for fringe benefits in the form of hospital insurance. The payment of premiums by employers spurred the growth of the Blue Cross Plans and was the stimulus for the increasing importance of insurance. However, it soon became clear that a significant number of people either lacked hospital insurance or had inadequate coverage. The serious shortcoming in the system was the linkage of coverage to employment. For the most part, if an individual lost his job or retired, he was likely to lose his insurance. Insurance companies demonstrated a serious lack of initiative in failing to provide for the continuation of coverage. Most insurance carriers refused to permit retirees to convert from a group policy to individual coverage, or permitted it only at a prohibitive cost.

Resistance to change seems almost universal in this country (academia, business, and government inclusive) and, as in this case, the neglect to devise new policy was only reinforced by the rigidities of bureaucracy. The conservatism of insurance companies was matched by the inaction of the government. In a 1949 report to Governor Thomas E. Dewey of

*Address delivered at the Annual Business and Industry Day, Raritan Valley Regional Chamber of Commerce, East Brunswick, November 9, 1978. Dr. Ginzberg is the A. Barton Hepburn Professor of Economics and Director of Conservation of Human Resources, Columbia University. He may be addressed at the University, 525 Uris Hall, New York 10027.

New York, I recommended that insurance companies be forced to convert policies from a group to an individual basis insituations where workers retired. No such action was taken.

The defects in the system began to be recognized in the mid-1950s when President Dwight D. Eisenhower and the Congress became concerned with this issue of coverage, particularly for older people. Under the prevailing mechanisms for financing health care, a majority of older people did not have medical insurance at the time they most would need such protection. In addition, the majority of existing insurance policies covered only inpatient treatment. Hospital protection for the aged moved to the forefront of Congressional debate, finally resulting in the passage of the Kerr-Mills Act in 1960. The compromise legislation made limited funds available to the states to enable them to provide medical care to low-income older persons, but it was not enough. More and more people were being forced onto the welfare rolls, brought to the point of insolvency because of their inability to meet payments for major medical care. It was not until 1965 that the problems in financing health care for older and low-income persons finally resulted in the enactment of Medicare and Medicaid.

THE FEDERAL GOVERNMENT TAKES OVER

Except for capital expenditures, philanthropy has all but disappeared from the health care arena, contributing less than two percent to hospital operating costs. With philanthropy moving out of the picture, the federal government has taken over a much enlarged role as financier for the health care system. In 1964, the year prior to the passage of Medicare and Medicaid, federal government expenditures were at about five billion dollars in total, including funds for the Veterans Administration, Armed Services, and the Public Health Service. Since then, in a period of fifteen years, the federal account alone has multiplied twelve times with a projected total of over 60 billion dollars in fiscal year 1979. Along with this tremendous increase in national expenditures for health has been the sizable increase in state expenditures and the further growth of private insurance. For the consumer, this means that two-thirds of his total medical expenditures are paid through third parties. (Drugs, dentistry, and some ambulatory care account for the remaining third.)

To sum up my brief post-WWI history, health care in the United States has undergone a transition. Once supported by an admixture of philanthropy and insurance, the health care system has grown tremendously to one that is quasi-governmental in size and range. In the light of this shift, particularly in terms of financial responsibility, I will discuss several issues that have come to the fore.

GOVERNMENT IS HERE TO STAY

The magnitude of the infusion of government funds into health care has established a fundamental change in the system: government is here to stay. If the government is putting in the dollars, it is inevitable that it will have much to say about how the money is spent.

Correlative to their expanded financial role, federal and state governments have come to exert ever more direct and indirect influence on the structure and operations of the health care system. This has increased the complexity of the system and created the need for more regulation and monitoring. In Washington, D.C., HEW personnel alone has multiplied by leaps and bounds. At the state level the

network involves state headquarters, Health Services Agencies (HSAs) and Professional Standards Review Organizations (PSROs). Hospital personnel has almost tripled since WWII, along with a substantial increase in wages. Many new bureaucracies have been put into place, accompanied by a costly administrative overhead that was not there previously.

INFLATION AND HEALTH CARE COSTS

Inflation and increases in health care cost also constitute a mounting problem for the trade unions. An increasingly large amount of the money that an employer is able to put on the table for collective bargaining is being absorbed by automatic increases in health insurance benefits. An example is the UAW-General Motors/Ford contract for health care benefits. Health care cost in the manufacture of each car exceeds the cost of steel. Yet even when premiums are being paid by employers, the money eventually comes out of the working person's pocket. If a premium rate goes up, the employer will take it into account in estimating his next wage proposal. Unions are not seeing the additional money that the employers claim they are putting on the table because it is eaten up by a 50 percent increase above inflation for health benefits. Surprisingly, there has not been much criticism about this up until now but both the employers and unions are realizing that the steep increases cannot continue indefinitely.

A major problem is the nature of the health care industry. Because it does not operate as a market system, there are no automatic controls to keep prices in check, such as competition among hospitals. Many of the established controls against excessive spending were dissolved by the large governmental sums that flowed into the health care system. The reimbursement mechanisms for hospitals encouraged indiscriminate spending. Many services now paid for through reimbursement used to be provided at no or little cost. Knowing that a third party—insurance companies or the government—will cover all their costs, hospitals increased their outlays. Consequently, the system is experiencing a sharp acceleration in the unit and total costs of care.

Public confusion over the present state of health care is compounded by the different perspectives and opinions on the reasons why the health care system costs are half again above the average rise of inflation. Arguments range from placing the blame on excessive technology or high salaries of physicians to the neglect of preventive medicine and too much surgery. There are no pat answers or interpretations of what ails the system. There are, however, several alternatives for improving it.

IMPROVING THE SYSTEM

One approach recognizes that a complex service such as medical care requires professionals in leadership roles. But, an industry approaching \$200 billion annual outlays should not be entrusted solely to the health establishment. Employers and trade unions just are beginning to recognize the problem and work together with the government to get a handle on accelerating costs. It is important that they continue these cooperative efforts. The professional leadership has a continuing role to play but other actors must be party to the decision-making.

One thing is certain: containment of the tremendous cost inflation is crucial; the recent rate of increase if unabated eventually will imply that health costs consume the entire GNP. I am skeptical about the effectiveness of tight cost controls slammed down by the federal government. Never-

theless something has to be done and there have been some modest successes in cost containment. For the past couple of years, the New York City Blue Cross has been able to contain rate increases and reimbursements to hospitals below the consumer price index. Certainly if this can be done in New York City, there are possibilities for similar results elsewhere.

Radical government intervention is not by itself going to accomplish much in the way of cost containment. Attempts to dictate strict productivity measures as recently suggested by Secretary of HEW, Joseph Califano, muddy the issue. First, efforts in the past to increase equity in access to care have generated much of the cost inflation. Further, the great increase in the use of facilities—especially by low-income families—during the past ten years must be seen in perspective. Some of this increased utilization was a gain for the poor; some may represent a loss. Quality is the important aspect of service delivery. Standards of output, such as the number of patients a community clinic must see, may increase exposure but do not guarantee improved care.

Although the earnings of professionals are not insignificant, the underutilization of excess resources contributes the most to cost inflation. Hospitals are poorly coordinated with the result that resource allocation and service delivery are below optimum. Regionalization is one way to begin to ameliorate this situation and would provide some of the experience necessary for rationalizing scarce health resources.

Following recent federal restrictions on the inflow of foreign medical graduates, there has been growing concern about the relation of manpower to service delivery. Currently one out of five physicians in this country is a foreign medical graduate. They play a critical role in the provision of health

care, particularly in metropolitan areas of the East. New Jersey is one state that relies heavily on foreign graduates and a sudden withdrawal may cause personnel shortages and insufficient coverage for low-income population groups. One way to alleviate the reduction of FMG's would be to make more use of nurse practitioners and physician assistants. This has worked well at Montefiore Hospital in New York City where surgical technicians have been used to replace residents in surgery. States, such as New Jersey, may want to reconsider their licensing policies in order to permit nurse practitioners and physician assistants to practice.

CONCLUSIONS

The post WWII expansion of the health care system was a response to public demand for more and better health care. The industry now employs one out of every twenty American workers and consumes over 8.6 percent of disposable income in the United States. It is a system that works imperfectly and expensively, characterized by much waste and duplication. Improved allocation and use of resources would yield greater benefits to more people—a desirable and critical goal if spiraling health costs are to be controlled.

The public should be aware of these problems and of the fact that their stake in the health care system is high. But at the same time, expectations must be tempered. In attaining a balance between equity and efficiency, the potentialities of health care in improving the quality of American life should not be exaggerated. And, it should be recognized that viewed in perspective with the other major services such as education, welfare, and criminal justice, health care performs reasonably well—which, in a democracy such as ours, is perhaps the most one can ask.

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ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control

secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Echocardiographic Features of Mitral Valve Prolapse*

JACK J. KLEID, M.D., Bronx, New York

The mitral valve prolapse (MVP) syndrome was first described by Barlow in 1963.¹ However, it has been only in the last six or seven years that this syndrome has gained widespread recognition. MVP has a broad spectrum of symptoms and physical findings which include chest pain, shortness of breath, palpitations, mid-systolic clicks, a late systolic murmur or both.² An occasional patient has associated abnormalities such as "straight back syndrome," Marfan's syndrome, osteogenesis imperfecta, ostium primum, and atrial septal defect.³ Electrocardiographic abnormalities, tachyarrhythmias and bradyarrhythmias frequently have been described in patients with MVP. Although the frequency of complications is low, endocarditis, severe mitral regurgitation and sudden death have been reported.^{5,6} In addition to the valvular abnormalities, some investigators feel that a cardiomyopathic element may be involved.⁷ This has not been proved definitely and remains controversial at the present time.⁸ Since the advent of echocardiography the diagnosis of MVP can be established more easily. Although neither angiography nor echocardiography has been established as the gold standard for diagnosing MVP, non-invasive echocardiography should be the screening procedure used in the assessment of the mitral prolapse syndrome. It most often will establish the diagnosis so that further invasive diagnostic procedures are not required.

ILLUSTRATIVE CASE AND DISCUSSION

A 30-year-old woman was referred to a cardiologist be-

cause of atypical chest pain, palpitations, and an abnormal systolic sound on auscultation. A diagnosis of mitral valve prolapse was suspected. In order to confirm the presumptive diagnosis an echocardiogram and phonocardiogram were performed (Figure 1). The findings of these non-invasive procedures were consistent with the diagnosis. The patient then was placed on propranolol (Inderal®) with subsequent symptomatic improvement.

Figure 2 shows a patient with normal echocardiographic mitral valve configuration. Note that in systole there is a gradual anterior motion (arrow) of the posterior mitral leaflet. However, in the patient with mitral valve prolapse (Figure 1) a posterior motion or "buckling" is seen in systole (arrows). This is due to the late systolic prolapse of the mitral leaflets into the left atrium. Note the ancillary finding of an abrupt posterior motion of the atrial wall (arrowheads) which is synchronous with the valve prolapse. The simultane-

*Edited by Ira L. Rubin, M.D. and Michael V. Cohen, M.D. Dr. Rubin is Clinical Professor of Medicine, Albert Einstein College of Medicine, New York; Attending Physician, Departments of Medicine and Cardiology and Chief of Electrocardiographic Service, Montefiore Hospital and Medical Center, Bronx, NY. Dr. Cohen is Associate Professor of Medicine, Albert Einstein College of Medicine, New York; Adjunct Attending Physician, Departments of Medicine and Cardiology, and Director of the Non-Invasive Laboratory, Montefiore Hospital and Medical Center, Bronx, NY. Dr. Kleid is Assistant Clinical Professor of Medicine (Cardiology), Albert Einstein College of Medicine, New York; Adjunct Attending Physician in Cardiac Non-Invasive Laboratory, Montefiore Hospital and Medical Center, Bronx, NY.

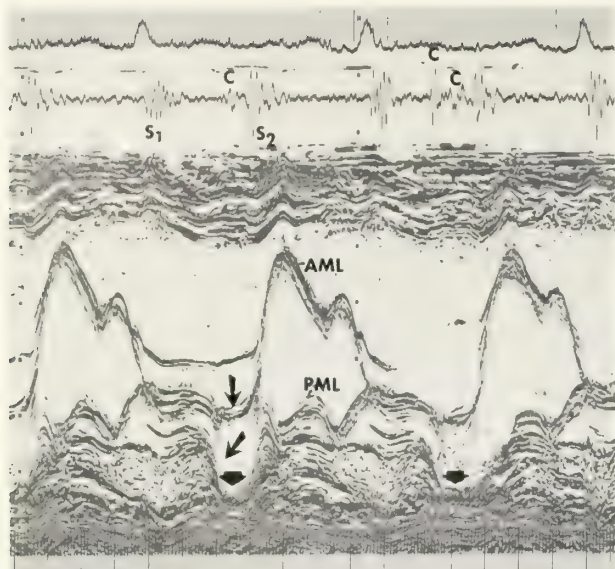


Figure 1—Echocardiogram from patient with mitral valve prolapse. Note end-systolic posterior motion (arrows). Arrowheads denote ancillary finding representing the left atrial posterior wall moving posteriorly at end-systole synchronous with the valvular prolapse.

AML= anterior mitral leaflet
PML= posterior mitral leaflet
S₁= first heart sound
S₂= second heart sound
C= click

ous phonocardiogram demonstrates a click appearing in late systole which is coincident with the nadir of the late systolic prolapse. It is also interesting to note that in one of the cardiac cycles there is a second mid-systolic click which coincides with the onset of the prolapse seen on the echocardiogram.

The author has seen and others have reported cases of silent mitral prolapse; that is, echocardiographic evidence of prolapse without auscultatory findings.⁹ Echocardiography is a fine tool for the recognition of MVP. However, the task of demonstrating echocardiographic prolapse is not always easy since several transducer angulations, different patient positions, and pharmacologic stimulation with amyl nitrite inhalation may be necessary. Experience is required by the echocardiographer to avoid missing the diagnosis as well as over-diagnosing the condition. Currently two-dimensional, real-time sector scanning is being utilized by several centers throughout the country for the assessment of MVP. In-

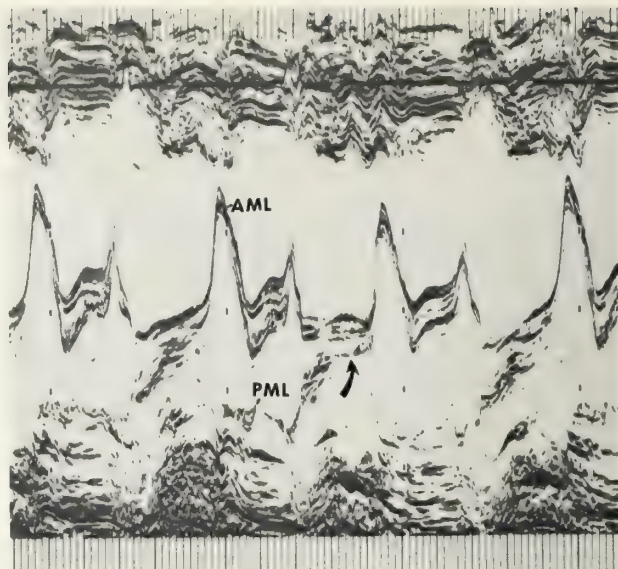


Figure 2—Normal mitral valve configuration. Note gradual anterior motion of anterior mitral leaflet in systole (arrow).

PML= posterior mitral leaflet

ing experience with this new and exciting technique may augment the sensitivity of the echocardiographic diagnosis of MVP.

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Selected Abstracts with Comments

Health Effects of the Pregnancy Use of Diethylstilbestrol (DES). Richmond JB. *DHEW Physician Advisory*, Oct. 4, 1978.

DES has been available since 1938. There is a definite association of intrauterine exposure to DES and clear cell adenocarcinoma in female offspring (DES daughters). Other DES daughters have developed benign vaginal adenosis. Mothers taking DES during pregnancy (DES mothers) have an increased incidence of breast and gynecologic cancers. Male offspring (DES sons) have an excess of genital anomalies including cryptorchidism, hypoplastic testes, and decreased sperm.

The risk of adenocarcinoma in DES daughters is less than 2/1000. Adenosis rarely, if ever, progresses to carcinoma and should be followed rather than aggressively treated. DES daughters should have thorough pelvic examinations with special tests (Pap smear and iodine staining) yearly beginning at menarche. DES mothers should have routine screening for breast and gynecologic cancer. DES sons should have a routine genital examinations to detect abnormalities.

The use of DES for post-coital contraception incurs a risk of possible existence of pregnancy and should be discouraged. DES use by DES mothers and daughters incurs additional risks and should be used prudently—perhaps avoided if suitable alternatives exist.

Comment: This is a brief summary of a report of the DES Task Force. The complete report can be obtained from the National Cancer Institute. (R.H. Rapkin, M.D.)

Failure to Thrive (FTT). Sills RH. *Am J Dis Child* 132:967, 1978.

One hundred eighty-five children who were less than three years old and who were under the third percentile for weight or had fallen at least two major percentiles were admitted to Buffalo Children's Hospital during a three-year period. Fifty percent had environmental deprivation as their proved etiology; 24 percent were of undetermined cause (most of these grew at the third percentile in follow-up and were probably normal); 18 percent had an organic etiology. History was most valuable in diagnosis of nonorganic FTT. History and physical *without* laboratory assistance was of most value in the diagnosis of organic FTT. Laboratory examinations were usually of no help. Only 1.4 percent of laboratory tests were "of positive diagnostic assistance" of which x-rays were most helpful. Since most FTT is environmental, a period of observation in the hospital is warranted before extensive laboratory investigation is considered.

Comment: Most patients with failure to thrive are diagnostic dilemmas because we have not carefully assessed the patient. A significant proportion of remaining questions of FTT subsequently are proved to be small but normal children. The careful primary care physician rarely will make a diagnosis of failure to thrive because he will have identified and ameliorated the problem long before it becomes an enigma. (R.H. Rapkin, M.D.)

I Can't Afford a B (editorial). Wolf SG. *N Engl J Med* 299:950, 1978.

Most medical school admissions' committees do not consider applicants with grade point averages (GPA) below 3.5. The aspiring medical student must select courses, therefore, that give him assurance of an "A" if he does well (eliminating things like philosophy and English literature). Medical schools may be barring abstract, analytic, creative, and reflective students in favor of concrete thinkers. Human judgment should become the main determinant for admission to medical school.

Comment: Medical studies require basic ability, but the best doctors are not necessarily the best performers on course examinations or aptitude tests. The moral and ethical dilemmas facing the physician today as well as the return to primary care and its ombudsman role require broadly based physicians, not narrowly programmed achievers. (R.H. Rapkin, M.D.)

Enkephalins: The Search for a Functional Role. (editorial) *Lancet* 2:819, 1978.

"The mammalian brain contains peptides, the enkephalins and endorphins, which have pharmacologic properties similar to those of morphine." Neural pathways can increase chronic pain thresholds by releasing endogenous substances. This can be antagonized by naloxone. Some groups of individuals may have higher thresholds than others because of endogenous production of enkephalins. Placebos may act by activating release and, again, naloxone can inhibit placebo action. In some patients with psychosis endorphins are increased in the CSF. Naloxone may be of value here too. This field is in its infancy.

*Abstracted from "Pediatric Department Newsletter," RMS, Vol. 3, No. 4 (Nov. 1978). Selections are made and original comments prepared by Richard H. Rapkin, M.D., then Professor of Pediatrics, RMS, CMDNJ, and his associates. Dr. Rapkin now is affiliated with New Jersey Medical School, CMDNJ, and is Medical Director, Children's Hospital, Newark.

Management of Premature Rupture of Membranes (PROM). Faye JA, *et al. Obstet Gynec* 52:17, 1978.

In a prospective study all patients with PROM were evaluated. Prior to 34 weeks patients were observed unless signs of amnionitis developed (if so, the patient was treated with antibiotics and induced). After 34 weeks patients were randomly observed or induced. Of those patients more than 34 weeks, 12 percent of the observed developed amnionitis compared to 4 percent of those induced. There was no RDS in the infants. Under 34 weeks there were several problems with infection, prematurity, and RDS. The incidence of amnionitis in all was related to the duration of PROM. It is concluded that PROM in gestations of 34 or more weeks should be delivered promptly.

The Relationship between PROM and RDS. Berkowitz RL, *et al. Am J Obstet Gynec* 131:503, 1978.

Three hundred and forty infants of 36 weeks gestational age or less were studied. PROM of 16 hours or more was associated with a reduced incidence of RDS in infants of 31 weeks or older. In the group between 33 to 36 weeks, there was only one RDS death when PROM exceeded 16 hours. If PROM was less than 16 hours, there were 8 deaths due to RDS. Induction after 16 hours may be reasonable in infants of 33 weeks age or more. Less than 33 week infants should not be delivered electively until 33 weeks. When amnionitis is clinically suspected, delivery is mandatory regardless of gestational age.

Comment: Being between the Scylla of amnionitis and the Charybdis of RDS is no fun. Studies like these help define the parameters and provide some objective guidance. (R.H. Rapkin, M.D.)

Antimicrobial Resistance and Enterotoxin Production among Isolates of E. Coli in the Far East. Eccheverria P, *et al. Lancet* 2:589, 1978.

E. Coli can produce diarrhea by producing cholera-like toxin. Transfer of this ability from E. Coli to E. Coli (and other gram-negative enteric rods) is mediated by an extrachromosomal piece of DNA (plasmid). Antibiotic resistance can be transferred from organism to organism by a similar mechanism.

In this study transfer of enterotoxin producing ability and antibiotic resistance frequently occurred together and might be encouraged by the widespread use of antibiotics.

Comment: Antibiotics exert selective pressures on bacteria. Here the selection is not just resistance to the antibiotic but also enterotoxin production. This is another warning that antibiotic use for the individual may affect the community of individuals. We must weigh the detrimental effects of what we do for our patient against what we do to our patients. (R.H. Rapkin, M.D.)

Milk and Soy-Induced Enterocolitis in Infancy. Powell GKJ. *Pediatr* 93:553, 1978.

The diagnosis of food "allergy" (if it is to be made accurately) is difficult, requiring multiple challenges and eliminations. There are several symptom complexes linked to protein intolerance including iron deficiency anemia from occult GI bleeding, exudative enteropathy, malabsorption syndrome, and an acute colitis syndrome with melena.

Using a simple set of criteria, infants with these syndromes may be more easily diagnosable. The criteria are: diarrhea within 24 hours of a challenge in which stools contain blood and leukocytes and a significant peripheral leukocytosis. Vomiting and acute carbohydrate malabsorption are frequently associated.

Comment: This is a superb review article worthy of careful reading and analysis. Infants who present with any of the following ought to be considered possibly protein intolerant: anemia, hypoalbuminemia, lactose intolerance, colitis, vomiting, diarrhea, and melena. Workup should be careful. Since many of the protein intolerant patients also may be or become soy intolerant, a protein hydrolysate formula probably should be used in treatment. R.H. Rapkin, M.D.

Problems of Spectrum and Bias in Evaluating the Efficacy of Diagnostic Tests. Ransohoff DF and Feinstein AR. *N Engl J Med* 299:926, 1978.

The efficacy of a laboratory test is its ability to indicate whether a disease is present or absent. If a patient has a disease and the test is positive, the test is sensitive. If he doesn't have the disease and the test is negative, the test is specific. If the patient has a positive test and has the disease, the test has accuracy for positive prediction, and if the patient has a negative test and does not have the disease, the test has an accurate negative prediction.

Many laboratory tests have not been evaluated properly by careful studies which independently assess true diagnosis and interpretation of the test. Such tests prove to be less valuable than originally thought.

Comment: Casscells *et al.* (*N Engl J Med* 299:999, 1978), state that if a healthy person were to have 25 screening tests only 28 percent would have 25 normal values. That is, 72 percent would have at least one abnormal result. In pediatrics, the mischief from overreaction to a falsely positive test far exceeds the dangers of missing clinically silent disease because of a false-negative test. That is because most of our patients are well and continue to do well despite us. If even "good" tests can mislead, where will we be led with tests that are poorly evaluated? (R.H. Rapkin, M.D.)

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THERAPEUTIC DRUG INFORMATION

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Brooklyn College of Pharmacy, Long Island University.*

1. Please provide information concerning the interference of cephalosporins with urine glucose determinations.

There are basically two methods used for urine glucose determinations—enzymatic and copper reduction.^{1,2} Clinistix®, Diastix®, and Tes-Tape® are examples of enzyme tests specific for glucose and provide a qualitative measurement of glycosuria. Benedict's test and Clinitest® rely on substances in the urine reducing copper ions to produce a color change which provide a quantitative measurement of glycosuria. Clinitest® remains the test of choice for determining urine glucose for regulation of insulin dosage.^{1,3} The cephalosporins are reducing substances and can cause false-positive color changes with Clinitest® that could lead to excessive insulin administration.^{2,4,5}

MacCara and Angaran² investigated the effects of cephalosporins on the Clinitest® reaction. Solutions of cephalothin (Keflin®), cefazolin (Ancef®, Kefzol®), and cephradine (Anspor®, Velosef®) were mixed with fresh human urine to provide varying drug concentrations. Different urine samples were prepared to provide varying glucose concentrations with and without the same drug concentrations. Clinitest® gave accurate estimates of glucose in all urine samples containing glucose only. Each of the cephalosporins produced a color change when tested with Clinitest® even though no glucose was present that varied from within the negative range to false-positives depending on the drug and concentration. In the combined glucose/cephalosporin urine samples, the concentrations of both the glucose and antibiotic produced varied results from no interference to inaccurate readings. Tes-Tape® and Diastix® readings were unaffected by the cephalosporins in urine.

In conclusion, Clinitest® should be avoided in patients receiving cephalosporins. Enzymatic glucose determinations may be used as an alternative but only provide a qualitative measurement of urine glucose.

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2. Do you have any information concerning metoclopramide?

Metoclopramide, a drug marketed in other countries, is currently under investigation by A.H. Robins Company in the United States, primarily for facilitating the following diagnostic procedures: peroral intestinal intubation, gastroduodenoscopy, and upper gastrointestinal radiology. Metoclopramide is a derivative of procainamide but devoid of anesthetic and cardiac actions. The primary pharmacological effects of interest involve the gut and the CNS. It has been shown to promote esophageal and gastric peristalsis, increase the tone of the cardiac sphincter, and speeds gastric emptying. Since metoclopramide inhibits the chemoreceptor trigger zone, it is useful for preventing nausea and vomiting.^{1,2}

Behar and Ramsby³ conducted a study to investigate the effect of oral metoclopramide in 13 patients with reflux esophagitis and sphincter incompetence. Their results suggested that the drug may be beneficial to such patients by reducing the volume of gastric contents.

McCallum et al.⁴ conducted a study to compare the effects of orally administered metoclopramide and bethanechol (Urecholine®) on lower esophageal sphincter pressure in patients with gastroesophageal reflux. The authors found that both drugs produced significant increase in lower esophageal sphincter pressure when compared to placebo. Metoclopramide, 20 mg, produced a greater increase than either metoclopramide, 10 mg, or bethanechol, 25 mg.

Christie and Arvent⁵ carried out a double-blind, crossover study of metoclopramide versus placebo for facilitating passage of a multipurpose biopsy tube in 34 subjects. The results indicated that intravenously administered

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, M.S., Pharm D.; T.H. Chin, Pharm. D.; R.J. Fuentes, R. Ph.; P. Sangkachand, M.S., R. Ph.

metoclopramide decreased intubation time compared to placebo and permitted intubation in some patients who otherwise may have been unable to undergo this procedure.

Klein *et al*⁶ conducted a study to evaluate the antiemetic effect of metoclopramide compared to prochlorperazine (Compazine®) and trimethobenzamide (Tigan®). They found that metoclopramide was as effective as prochlorperazine in preventing apomorphine-induced vomiting but superior to trimethobenzamide.

In conclusion, metoclopramide appears to normalize inefficient motor function of the upper gastrointestinal tract. It may be useful in the treatment of gastrointestinal reflux, as an antiemetic, in facilitating endoscopy and passage of the multipurpose biopsy tube.

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3. How does the new beta-adrenergic blocker metoprolol compare to propranolol?

Metoprolol (Lopressor®) was developed about ten years ago for the purpose of more selective beta 1—adrenoreceptor antagonism. This selectivity may have cardiac, vascular, pulmonary, and metabolic implications.

Metoprolol, although effective for angina, currently is approved only for the treatment of hypertension.^{1,2} Metoprolol and propranolol (Inderal®) seem to have comparable antihypertensive^{3,4} activity, and it has been proposed that 50 mg of metoprolol is equipotent to 40 mg of propranolol on hemodynamic effects⁵. However, metoprolol can be dosed on a twice daily basis compared to the recommended four times daily schedule for propranolol.

The beta 1 selectivity of metoprolol diminishes as the dose is increased and thus, at higher dosages, it then would have the same spectrum of beta blocking activity as propranolol.^{6,7} However, unlike propranolol, metoprolol does not have myocardial members stabilizing properties rendering it useless in the treatment of some conduction arrhythmias.⁸

A possible advantage of metoprolol over propranolol is in the treatment of hypertensive patients with concurrent peripheral vascular disease (eg. Raynaud's syndrome, ischemia, and others), since the beta 2 vasodilating response is blocked to a lesser degree.⁹ However, this has been disputed by Pickering¹⁰ who cites various pathophysiological limitations to this theory.

In cases of bronchospastic disorders, metoprolol, at lower doses, adversely influences pulmonary function tests to a lesser degree than propranolol. Unlike propranolol, which is contraindicated in patients with COPD or asthma, metoprolol at a dosage level of 100 mg/day, administered two to three divided doses, combined with a beta 2 agonist such as terbutaline (Brethine®), can be used with caution in such patients.

The metabolic effects of metoprolol and propranolol were compared by Waal-Manning¹³. In a series of patients undergoing glucose tolerance tests, decreased plasma glucose and increased plasma insulin levels resulted when patients were changed from non-selective beta blockers to metoprolol. This effect most likely was related to its lesser beta 2 blocking activity and may be of significance to the diabetic. This same investigator reported greater depression of plasma renin activity by metoprolol than propranolol, possibly an advantage in the treatment of high renin hypertension¹³. On the other hand, metoprolol had a greater propensity to increase plasma triglycerides than to propranolol¹³. The significance of these metabolic effects deserves further study.

In conclusion, metoprolol is indicated only for the treatment of hypertension. In low doses metoprolol tends to provide more selective beta blockade than propranolol. The drug is indicated only for the treatment of hypertension and the efficacy and side effects appear to be quite similar to propranolol.

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No Answers—Just Questions

A recent housecleaning of my drug cabinet after thirty years of practice gave me quite a jolt. I found medications that almost could be a basis for malpractice if used now, but at one time were good medical practice. Some questions—If good practice then, and malpractice now, how can the legal profession and judiciary be so certain of what constitutes malpractice now?

When corticosteroids appeared on the scene, we were sure that therapeutic answers were at hand for treatment of arthritis and asthma. Thirty years later, we are hard put trying to improve on aspirin for various rheumatic disorders and sympathomimetics for asthma. What happened to all those other things that were being taught in therapeutics when I went to medical school? Duodenal lavage, gastric lavage, high colonic enemas? Perhaps keeping ourselves "crazy clean" is not "in" anymore.

Treatment for obesity? Hypertension? The list of remedies past and present for either one surely would fill this page. At the moment, strict control of hypertension appears to be "de rigeur" just as rigid control of hyperglycemia used to be.

Vitamins in mini to mega dosage have been advocated for practically all of man's ills including libido and potency. Poisons of all types used to toxicity have come and gone: strychnine, arsenic, mercury, gold, silver, and others.

The popularity of some drugs seems to wax and wane much like clothing fashions—the rise and fall of female hem lines and the width of men's ties and clothing lapels. When I started practice, coronary spasm was acceptable, then became unacceptable, and now has become acceptable again. Nitroglycerin, previously contraindicated in heart failure and acute myocardial infarction, now appears to be useful. Quinidine has been in and out of favor several times since my medical school days. Now, even the usefulness of maintenance digitalization after heart failure has been controlled is being questioned.

The parade of new therapeutic modalities seems to have no end. If one believes the advertisements in the medical journals and keeps up with current literature, they all have great merit. In the last century, Latham stated "there is nothing edible or potable in the world which has not found somebody or other to eat it or drink it as a sovereign remedy for some disease and upon the recommendation of some physician." And Osler said, "man has an inborn craving for medicine. Heroic dosing for several generations has given his tissues a thirst for drugs. The desire to take medicine is one feature which distinguishes man from his fellow creatures." Some distinction!

The advocates of coronary artery by-pass surgery approach dogma in their conviction about the efficacy of this procedure. Evidence is now being presented that it will prolong life. Radical mastectomy devised by Halstead has been done for the past 50 years to prolong life. Now evidence is being presented that it does not prolong life. I can recall similar conviction about the advocacy of earlier procedures for coronary disease: Beck I, Beck II, omentopexy, poudrage, internal mammary ligation, internal mammary sham ligation, internal mammary transplant (Vineberg), coronary endarterectomy (Bailey), and total thyroidectomy resulting in myxedema.

The medical treatment for coronary artery disease also has had interesting changes. Remember Khellin, testosterone, and papaverine? Until recently, one would be subject to severe criticism if one did not anticoagulate *all* patients with acute myocardial infarction: and now—? For the past several years, *all* acute coronaries were being admitted to intensive care units. Now some say home care is just as good for most. Not too long ago, we were using aggressive medical approaches for the treatment of cardiogenic shock: vasopressors, vasodilators, plasma expanders, and so on. Now balloons and other mechanical devices seem to be the thing.

More surgical procedures come to mind: sympathectomy (Smithwick) and adrenalectomy for hypertension, tonsillectomy for "large tonsils," appendectomy for "chronic appendicitis," nephropexy for ptosis of the kidneys and other general "hitching up" procedures for various forms of "visceroptosis," small bowel resection for hyperlipidemia and obesity, and ever-changing variations of gastric and vagal surgery for duodenal ulcer. The long list of medications for duodenal ulcer included extract from pregnant mares' serum. Currently H-2 blockers appear to be number one on the hit parade.

Even third-party providers have caught on. Some of my patients have received a letter which begins "a review was conducted by the public health service and it was found that certain procedures are of dubious effectiveness or outmoded and have been replaced by more advanced modalities of diagnosis or treatment." The list includes ballistocardiograms, phonocardiograms, TBI, PBI, BMR, icterus index, ceph flocc, thymol turbidity, BSP, and others. At one time of "proved value," they are no longer indicated or compensable. The new list includes "advanced" diagnostic procedures utilizing radioactive materials, computers, and other space age techniques. Treadmill testing and other forms of

stress testing are replacing the long-established Master "two-step" test. Anyone using the latter tends to be looked upon as archaic. Now we are hearing that up to 50 percent of positive treadmill tests on asymptomatic patients may be falsely positive, especially in the female. Is new always better? Diagnostic procedures costing less than one hundred dollars now are being replaced by procedures costing more than a thousand dollars. How sure can we be that the increased cost will be proportionate to the yield in diagnostic acuity? Least compensable is the time required for a comprehensive history which has a proved high diagnostic yield.

The current status of blood lipids with relation to coronary risk factors appears to be in a state of indecisive turmoil. At a recent meeting in cardiology, some of the leading authorities in the field produced some rather startling statements.

"Once arteriosclerosis starts it cannot be retarded."

"No drug is of really proved efficacy in prevention of coronary disease."

"Atromid is of no value and even may be harmful."

"Elevated triglycerides are not a risk factor in development of coronary artery disease."

"Obesity is not a risk factor."

"Dietary restriction of cholesterol has very trivial and clinically insignificant effect on blood level of cholesterol."

It could be a problem of vantage point. The innovator working in the realm of the teaching medical centers sees patients at the initiation of a new therapeutic regimen or diagnostic procedure. The physician out in the field observes the patient over the long haul and may indeed be in a better position to evaluate the efficacy of these innovations. He develops a skepticism derived from exposure to a long series of reverses and failures. Selective skepticism can be therapeutic. But, alas, his voice is hardly heard.

From my own vantage point, even Osler's numbers were understated when he wrote "the young physician starts life with twenty drugs for each disease, and the old physician ends life with one drug for twenty diseases".

Irvin Sussman, M.D.

The Waters of New Jersey...



of Benefit to All!



New Jersey has 1,792 miles of bountiful coastline—or 15 inches per citizen for their enjoyment and the enjoyment of visitors today and tomorrow. To insure a bright future for this important land area, the living sea and surrounding inland waters, we must recognize the need for their wise use and sensible development.

Fortunately, New Jersey is served by an organization dedicated to marine science education and research, helping New Jersey residents and industry to improve their awareness and understanding of the coastal environment and how they may best enjoy it.

The Consortium serves as a clearing house to initiate, coordinate and integrate marine science education and research in the state for both learning institutions and commerce. It has a membership of 23 colleges and universities with field offices in the Northern and Southern sections of the state and executive offices in Princeton.

The Consortium supports research and development through individuals and multi-disciplinary teams, educational programs in the classroom, in the field and on the sea.

It offers advisory services to assist individuals and organizations to obtain and exchange marine-related information at all levels.

In addition to the obvious need to conserve our shore areas for recreation, the Consortium recognizes the critical role these land areas play in our daily lives. For example, you may be surprised to learn that over 90% of all the commercial fish, shrimp, crabs, oysters, and countless other forms of marine life spend their early lives in the shelter of these wetland environments. New Jersey scientists have also found that wetlands are a natural barrier which keep underground supplies of fresh water from mixing with the undrinkable water of the



sea, thus providing thousands of New Jersey residents with pure well water. And, the state's barrier beaches and wetlands act as a natural buffer zone between the violence of the stormy ocean and the land where man lives and works.

The New Jersey Marine Science Consortium is a tax-exempt, non-profit marine education and research organization. You are invited to visit our facilities and take advantage of our many programs for students and the general public.

For more information write to:



Dr. Robert Ellis, Executive Director
New Jersey Marine Science Consortium
101 College Road East, Princeton, N.J. 08540
609-452-8465

**NEW JERSEY
MARINE SCIENCES
CONSORTIUM**

DOCTOR'S NOTEBOOK

Trustees' Minutes May 15, 1979

The reorganization meeting of the Board of Trustees was held in Atlantic City on Tuesday, May 15, 1979. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Introduction of New Members . . . Welcomed Palma E. Formica, M.D., of the third district, and John A. Surmonte, M.D., of the fifth district, newly elected members of the Board of Trustees, and noted that Howard D. Slobodien, M.D., had been named Second Vice-President, Armando F. Goracci, M.D., First Vice-President, and Augustus L. Baker, Jr., M.D., President-Elect.

Election of Chairman of the Board . . . Reelected James S. Todd, M.D., Chairman of the Board of Trustees, and agreed to continue meeting on the third Sunday of each month, providing there is an adequate agenda and the date does not conflict with the AMA or other major meetings.

Committee on Finance and Budget . . . Reappointed William Greifinger, M.D., to membership on the Standing Committee on Finance and Budget for a three-year term, 1979-1982.

Investigation of Pharmacies . . . Directed that the Executive Committee meet with the State Board of Medical Examiners (who had requested the names of physicians willing to provide prescriptions for drugs to be used as part of an investigatory procedure, relating to retail pharmacies suspected of violating statutes regarding the dispensing of drugs) to discuss the issue. Previously the Board has agreed to participate in this procedure but there are reservations about continued involvement in the investigatory procedures.

Anesthesiologists' Allowances . . . Directed that a copy of Resolution #10

—Establishment of a Committee To Assist Physicians in the Art of Negotiating—be sent as an appropriate response to the inquiry of the New Jersey State Society of Anesthesiologists who are attempting to rectify, through negotiations, economic injustices experienced by anesthesiologists with third party payers.

Vacancy on Council on Mental Health . . . Directed that the New Jersey Psychiatric Association be asked to make a recommendation for replacement on the Council on Mental Health for Ralph J. Fioretti, M.D., who has resigned. The matter had been referred to the Board by the House of Delegates and appointment has been withheld pending receipt of the above-mentioned recommendation.

Physician Assistant Support . . . Directed that Resolution #1—AMA Reconsider Physician Assistant Support—be referred to the New Jersey Delegation to the AMA for preparation of a resolution to be presented to the AMA House of Delegates:

RESOLVED, that the Medical Society of New Jersey, through its Delegates to the American Medical Association, by proper resolution, ask the AMA to change its position of support for physician assistants to one of active opposition.

Gas Rationing . . . Directed that Resolution #5—Gas Rationing for Health Personnel—be referred to:

1. MSNJ's public relations office for a press release;
2. the New Jersey Department of Energy;
3. the New Jersey Delegation to the AMA for preparation of a similar resolution for presentation to the AMA House of Delegates.

RESOLVED, that the Medical Society of New Jersey go on record that physicians, nurses, and other health professionals be allocated sufficient gasoline to take care of patient needs adequately; and be it further

RESOLVED, that the Medical Society of New Jersey contact all departments of government at the state level that are concerned with fuel energy rationing to effectuate these aims; and be it further

RESOLVED, that the New Jersey Delegates to the AMA be instructed to draft a similar resolution for presentation at the next meeting of the AMA House of Delegates so that these goals may be attained at the national level.

Rule on Amphetamines . . . Referred Resolution #31—Rule on Amphetamines and Sympathomimetic Amine Drugs—and Resolution #33—Rule on Amphetamines—to the Executive Committee and directed that these resolutions be discussed with the State Board of Medical Examiners in an effort to resolve problems of mutual interest.

Resolution #31
RESOLVED, that the House of Delegates request the Medical Society of New Jersey actively to support repeal of Rule 13:35-6.16—Uses of Amphetamines and Sympathomimetic Amine Drugs, recently promulgated by the State Board of Medical Examiners.

Resolution #33
RESOLVED, that the House of Delegates reaffirm its approval of Resolution #31 from Mercer County, which requests that the Medical Society of New Jersey actively support repeal of Rule 13:35-6.16—Uses of Amphetamines and Sympathomimetic Amine Drugs, the effect of which repeal would then leave sufficient laws in effect to deal adequately with any problems of true abuse; and be it further

RESOLVED, that the Medical Society of New Jersey do all in its power through persuasive (such as the Board of Trustees having conferences with the Board of Medical Examiners), legislative (such as reexamining and having appropriate changes, at long last, made in the Medical Practice Act), and even legal means, to investigate thoroughly the whole tone and thrust of the operations of the State Board of Medical Examiners and, if deemed necessary, changing it from an enforcement and surveillance arm of the Department of Law and Public Safety of the State Attorney General's Office to one of a helpful, advisory capacity, giving warnings to physicians deemed to be out of line, and becoming responsive to physicians seeking information and advice.

Statewide IPA/HMO Project . . . Directed that President Alessi appoint a task force to study the feasibility of the development of a multi-service area HMO in accordance with the following two recommendations which had been incorporated in the summary report presented by the New Jersey Foundation for Health Care Evaluation, and that position statements of the Crossroads Health Plan and Southshore Health Plan, and any other materials pertaining to the development of a single statewide IPA/HMO are to be made available for consideration by the task force:

1. To endorse and support the development of a multi-service area HMO as described in the report.
2. To establish a task force with the responsibility for overseeing its implementation.

Reduced Dues for New Physicians . . . Directed that Resolution #9—AMA and MSNJ Reduced Dues for Physicians—be referred to the Committee on Revision of Constitution and Bylaws for an appropriate amendment:

RESOLVED, that the Medical Society of New Jersey adopt a reduced-dues category for physicians first entering practice; and be it further

RESOLVED, that this reduced-dues category incorporate both MSNJ and AMA dues; and be it further

RESOLVED, that this one-year reduction in both MSNJ and AMA dues be 50 percent for a physician's first year of practice post-residency in New Jersey.

Art of Negotiating . . . Directed that President Alessi appoint a committee to work with the Council on Medical Services in developing a program to assist physicians in the art of negotiating, in accordance with Resolution #10—Establishment of a Committee To Assist Physicians in the Art of Negotiating:

RESOLVED, that the Medical Society of New Jersey proceed immediately to establish a committee, sufficiently large as to be available in all areas of the State, that will be trained in the art of negotiating, to assist physicians in such circumstances.

Basic Nursing Education Programs . . . Directed that a copy of Resolution #15—Support for the Present Basic Nursing Education Programs—be sent to the Governor, members of the New Jersey Senate and General Assembly, the Commissioner of Education, and that a press release be issued.

RESOLVED, that the Medical Society of New Jersey continue to support the existence of present basic nursing education programs with the understanding that the curriculum will be changed as necessary to meet society's changing needs; and be it further

RESOLVED, that the Medical Society of New Jersey voice its support, and *actively support the expansion of such programs*, including the practical nursing program, the diploma school nursing program, the associate degree program, and the bachelor degree program to allow maximum variety of specialization of nurses needed in our complex health care environment; and be it further

RESOLVED, that copies of this resolution be sent to the Governor of New Jersey, the Commissioner of Education, the New Jersey Senate and Assembly, and to the press.

. . . Directed further that the Executive Committee meet with the Joint Practice Committee, the New Jersey Hospital Association, and the National Association of Nurses to discuss this issue.

Note: It was pointed out that the New Jersey State Nurses Association supports the proposal that by 1985 a Bachelor of Science degree in Nursing will be required to enter the professional practice of nursing. The Association is against hospital-based nursing programs. If hospitals are forced to close or modify their programs, funding of these hospitals by the State could be in jeopardy.

Availability of Smallpox Vaccine . . . Referred Resolution #26—Availability of Smallpox Vaccine—to the Council on Mental Health for implementation:

RESOLVED, that the Medical Society of New Jersey study the availability and distribution problems which developed as a result of the decrease of smallpox immunization; and be it further

RESOLVED, that the Medical Society of New Jersey prevail upon the pharmaceutical companies and the local health departments for a more feasible method of distribution and availability.

Crop Support for Tobacco . . . Directed that notification of MSNJ's position of opposition to further federal subsidy of tobacco crops—Resolution #28—Encourage Withdrawal of Crop Supports for Tobacco—be forwarded to New Jersey's United States Senators and Congressional Representatives, that a press release be issued, and that the resolution be referred to the New Jersey Delegates to the AMA for preparation of a similar

resolution:

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to further federal subsidy of the tobacco crop; and be it further

RESOLVED, that notification of this position be forwarded to the Senators and Representatives from the State of New Jersey, and otherwise publicized and made known; and be it further

RESOLVED, that a similar resolution be submitted for approval by the American Medical Association; and be it further

RESOLVED, that the following statement be approved as policy of the Medical Society of New Jersey:

It is indefensible for governmental action to lend financial support to an addictive habit which is destructive to the health, welfare, and property of the American people.

Drug Price and Quality Stabilization Act

. . . Directed that Resolution #29—Prescription Drug Price and Quality Stabilization Act—be referred to the Council on Legislation for drafting of appropriate legislation.

RESOLVED, that to accomplish the whereases, the Medical Society of New Jersey, through its legislative channels, amend the Prescription Drug Program Act so that every prescription dispensed under this Act includes the following:

(a) Labeling of the prescription as to its generic name or brand name, unit dosage, amount dispensed, and expiration date, unless the physician specifies "do not label."

(b) The pharmacist must record on the patient's drug file the name and source, drug manufacturer's lot and batch number of the drug prescribed.

(c) The drug manufacturer must identify to the pharmacist the drug as to its source, lot and batch number.

(d) In the event of a drug recall, the State Drug Utility Review Council shall be notified by the drug manufacturer as to the drug lot and batch number.

Blue Shield Regulations . . . Directed that information be obtained from Blue Shield before taking any action to effect a change in regulations as called for in Resolution #12—Blue Shield Regulations:

RESOLVED, that the Board of Trustees effect a change in Blue Shield regulations that would allow participating physicians to receive fees from major medical contracts; and be it further

RESOLVED, that the Board of Trustees pursue this matter to completion with the New Jersey Commissioner of Insurance should it be necessary to do so in order to accomplish the intent of the resolution.

Family Practice Department . . .

Directed that the Executive Committee meet with Dr. Stanley S. Bergen, Jr., M.D., President of the College of Medicine and Dentistry of New Jersey, to consider the following recommendation of the Reference Committee:

That this problem be referred to the Board of Trustees of the Medical Society of New Jersey for consideration of other means of persuasion to develop this Department of Family Practice (such as different use of AMA-ERF funds).

Note: Resolution #16—Fund Family Practice Department—which dealt with the subject, had been rejected on recommendation of the Reference Committee who offered the above recommendation.

Legal Drinking Age . . . Directed that a copy of Resolution #17—Legal Drinking Age—be sent to the members of the New Jersey Senate and General Assembly and that a press release be issued to inform the public of the concern of physicians in the welfare of children.

RESOLVED, that the Medical Society of New Jersey endorses raising the legal age of drinking to the age of 21; and be it further

RESOLVED, that copies of this resolution be sent to members of the New Jersey Legislature and to the press so that the community can be informed of our commitment and responsibilities undertaken as physicians on behalf of the welfare of our children.

Physician-Patient Relationship and Third-Party Payers . . . Directed that Resolution #18—Legislation to Prevent Damage to Physician-Patient Relationship by Insurance Companies and/or Governmental Agencies—be referred to the Council on Legislation for implementation.

RESOLVED, that the Medical Society of New Jersey seek to initiate legislation to prevent insurance companies and/or governmental agencies from phrasing their denial of coverage or benefits in such a way as to cause the patient to believe his physician actively participated in an adverse decision; such legislation to carry substantial penalties for violation.

Seat Belts on School Buses . . . Directed that a formal request be sent to the leaders of the New Jersey Senate and General Assembly to initiate legislation to mandate that installation of seat belts or other restraints on school buses, as called for in Resolution #19—Mandatory Installation of Seat Belts or Other Restraints on School Buses—and that a press release be issued to inform the

public that MSNJ supports this measure.

RESOLVED, that the Medical Society of New Jersey petition the New Jersey legislature to make the presence of seat belts or other restraints in school buses mandatory.

Bioptic Lens . . . Directed that Resolution #30—Bioptic Lens—be referred to the Council on Legislation for its information, and that a letter be sent to the Director of the Division of Motor Vehicles advising of MSNJ's opposition to the use of any telescopic lens as a means of passing the licensure examination;

RESOLVED, that the Medical Society of New Jersey actively oppose any bill proposed by the legislature advocating the use of any form of telescopic lens as a means of "passing" the drivers' test in New Jersey.

Insurance Benefits for Psychiatric Care . . . Agreed to postpone consideration of Resolution #20—Insurance Benefits for Psychiatric Care—until an appropriate study and report are completed:

RESOLVED, that the House of Delegates specifically commits the Medical Society of New Jersey to the policy of the AMA regarding the treatment of emotional and mental illness, and instructs its Board of Trustees and Officers to institute all measures within its power to ensure that the people of New Jersey will receive the quality of medical care envisioned in the policy of the AMA House of Delegates, through the provision of benefits for the care of emotional and mental illness under all government and private insurance programs, equivalent in scope and duration to those benefits provided for other medical or physical illness.

Multiphasic Screening Program . . . Referred Resolution #21—Multiphasic Screening Program—to legal counsel for investigation of the existing law and his opinion as to the possible legal ramifications if the procedure called for is implemented:

RESOLVED, that the Medical Society of New Jersey petition appropriate state agencies to require that health fairs and other multiphasic screening programs send test results directly to the patient, indicating any abnormal results and with instructions to contact his/her personal physician when appropriate; and that such test results in no case be conveyed directly to the physician named by the patient; and be it further

RESOLVED, that patients be notified by such test centers that it may be proper medical procedure for the attending physician to repeat abnormal tests.

Regulation and Cost Containment . . . Directed that a copy of Resolution #22

—Regulation and Cost Containment—be forwarded to the New Jersey Hospital Association and the State Commissioner of Health, and that the New Jersey Delegation to the AMA be instructed to prepare a similar resolution for presentation to the AMA House of Delegates in July:

RESOLVED, that as part of its voluntary health cost containment program, the Medical Society of New Jersey support the New Jersey Hospital Association's endeavors to eliminate costly, unnecessary overlapping both of inspection and regulatory mechanisms; and be it further

RESOLVED, that the AMA Delegation introduce and speak for a similar resolution at the next meeting of the AMA House of Delegates.

Satellite Clinics . . . Directed that Resolution #23—Restriction on the Establishment of Satellite Clinics—be referred to legal counsel for analysis of the possibility of ramifications in implementing the resolution:

RESOLVED, that the Medical Society of New Jersey demand that the New Jersey Department of Health and the New Jersey Department of Human Services seek the advice and consultation of the local county medical society, which is most acutely aware of local medical needs, before granting permission for the establishment of a free-standing hospital satellite clinic.

Note: A question was raised whether the placing of restrictions on the establishment of free-standing hospital satellite clinics could be in violation of the certificate of need as it exists.

South Jersey Medical Education Program . . . Directed that notification to the membership of MSNJ's endorsement and support of the Board of Higher Education's position (Resolution #32—South Jersey Medical Education Program Clinical Campus) be accomplished through the *Membership Newsletter*, and to the Governor, the members of the legislature, and the Board of Higher Education by a separate communication.

RESOLVED, that this House of Delegates endorses and supports the position of the Board of Higher Education; and be it further

RESOLVED, that the Medical Society of New Jersey have representatives appointed by the President of the College of Medicine and Dentistry of New Jersey, with the approval of the Chancellor of Higher Education, to participate actively in any future review of the South Jersey Medical Program conducted by the State of New Jersey or any of its agencies; and be it further

RESOLVED, that the Board of Trustees make known this endorsement to the members of the Medical Society of New Jersey, the Governor, the members of the legislature, and the Board of Higher Education.

Note: The position of the Board of Higher Education is that:

(1) it is academically and economically unsound to construct a basic science facility for either allopathic or osteopathic students in South Jersey;

(2) a clinical campus be established for allopathic students in Camden and osteopathic students in Stratford;

(3) a small administrative building be constructed for the offices of the clinical faculty and classrooms for allopathic and osteopathic students.

New Jersey State Medical Underwriters, Inc.—

1. Appointment of Members to Board of Trustees . . . Approved the appointment of James E. George, M.D., J.D., Paul J. Kreutz, M.D., and James S. Todd, M.D., to the Board of Directors of the New Jersey State Medical Underwriters, Inc. John S. Madara, M.D., was reappointed to serve as the designated representative of the President of the Medical Society of New Jersey.

2. Shareholders' Meeting . . . Approved the appointment of Vincent A. Maressa as the representative of MSNJ to vote the shares of the Society at the next annual meeting of the shareholders of the New Jersey State Medical Underwriters, Inc.

. . . Approved the following instructions concerning that vote—for election to the Board of Directors: James S. Todd, M.D., Paul J. Kreutz, M.D., and James E. George, M.D., J.D.; for election of Ernst and Ernst as independent auditors of the New Jersey State Medical Underwriters, Inc.; for a resolution amending the Bylaws of the New Jersey State Medical Underwriters, Inc. to the effect that:

(1) The term of each director (other than those holding such position by virtue of being an executive director or president (or his designee) shall be for three years.

(2) For purposes of implementing the foregoing, the term of James S. Todd, M.D., shall be one (1) year; James E. George, M.D., J.D., two (2) years; Paul J. Kreutz, M.D., three (3) years (as they may unanimously agree, or by lot).

Admission of Media into New Jersey Courtrooms . . . Agreed that proceedings involving professional liability intent should be excluded from media recordings and directed that a letter to this effect be sent to Chief Justice Richard J. Hughes and Judge Arthur J. Blake.

MSNJ Student Association . . . Referred a recommendation from the MSNJ Student Association, concerning the matter of granting students voting rights, to the Special Committee on Long Range Planning and Development for study.

National Health Insurance . . . Noted that since the House of Delegates did not adopt the resolution sponsored by the Board concerning National Health Insurance, MSNJ has no position on National Health Insurance and the Delegates to the AMA will be required to vote conscientiously on this item at the AMA meeting in July.

Annual Meeting Attendance . . . Noted that attendance at the 1979 Annual Meeting was the lowest recorded in the last six years.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Much attention is being directed toward the prospective rate-setting programs for hospitals now under way in New Jersey. HCFA (the Health Care Financing Administration of HEW) is looking to the New Jersey project to reduce costs substantially. The passage last year of S-446 created a five-person, rate-setting commission, which has started to function. A major component of the rate-setting system (which will affect *all* hospitalized patients) is the use of Diagnosis Related Groups, or DRGs. DRGs have been addressed in this space and elsewhere in MSNJ and NJFHCE writings for several years. DRGs are statistically-related groups of diagnoses which correspond to one another in terms of intensity of care. The "case

mix" of a hospital's patient population is another consideration. The overall use of hospital resources is analyzed. Length of stay and use of ancillary services are major components. Various "cost centers" of hospitals are identified and compared. The economic/statistical aspects of the method are of little interest to physicians, but the results of the analyses in terms of hospital budgeting will be a major concern for administrators. Physicians will take more notice if the concept of payment by diagnosis (and not by days in the hospital, services, procedures, and so on) takes hold.

The New Jersey Professional Standards Review Council has undertaken the task of bringing the PSROs and the DRG program together to discuss common concerns, chiefly involving quality assurance. NJFHCE, as the PSRO Support Center, has conducted such programs in the past. Now, the Health Standards and Quality Bureau (HSQB), which oversees the PSRO program, has indicated its interest in New Jersey's DRG program, and the State Council, of which NJFHCE is the administrative arm, will continue this work. As you know, MSNJ, NJFHCE and others participated in the Commissioner's Advisory Committee, which identified quality assurance parameters for 30 of the DRGs. Questions arising from DRG data will be referred to PSROs.

Reference has been made here several times to the need for accuracy in recording diagnoses and procedures in the hospital record, particularly on the face sheet. Erroneous recording of major diagnoses and major procedures (those which consume the most resources) can result in the case falling into the wrong DRG. If this occurs often enough, it can affect the reimbursement of the hospital. If some of the long-term plans come to pass, such errors could affect payment of physicians, also. The New Jersey Utilization Project (NJUP) is conducting a series of seminars at various hospitals around the State on this subject of accuracy.

No predictions can be made at this point on the eventual effectiveness of DRG or prospective rate setting. MSNJ has endorsed the concept of DRG as an experiment, and is reserving judgment on its eventual usefulness. NJFHCE's posture is the same. Some of the effort is the result of preconceived notions as to the capabilities of the system. Whatever the outcome, physicians should keep informed and be aware. This is typical of the many palatable things NJFHCE tries to inform you about.

Update on the New Jersey Division of Vocational Rehabilitation Services (DVRS)*

The Division of Vocational Rehabilitation Services offers many services to persons having physical or mental disabilities which are substantial handicaps to employment. Medical evaluations and therapy, appliances, training, job placement, and counseling are available. Early referral is indicated where lengthy disability is indicated.

Some of your patients may be eligible for DVRS services. Years ago, when it was known as the New Jersey Rehabilitation Commission (NJRC) most of the persons served had disabilities of a "mechanical" nature, i.e., amputation, paralysis, and so on. Orthopedic surgeons, neurosurgeons, and physiatrists were familiar with "NJRC" and its operations, but many primary physicians were unaware of its functions, since most of their patients were not in the "disabled" category.

The scope of DVRS has broadened considerably since the 1960's, and more so since the Rehabilitation Act of 1973 was made law. DVRS, a Division of the Department of Labor and Industry, operates under State and Federal regulations, with funding from each on a matching basis.

ELIGIBILITY FOR SERVICES

The emphasis on cancer, heart disease, and stroke brought those disorders into eligibility and the Act of 1973 broadened the emphasis to include the most severely handicapped individuals. Patients with a variety of chronic disabling conditions became eligible for services but not all patients with all diagnoses qualify.

The conditions for eligibility are: (1) the presence of a physical or mental disability; (2) the existence of a substantial handicap to employment, and (3) a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

DEFINITIONS

"Vocational Rehabilitation Services" means the provision of such goods and services which reasonably can be ex-

pected to benefit a handicapped individual in terms of his employability. It also means the provision of such goods and services to an individual for the purpose of determining whether his employability might improve from the provision of rehabilitation services.

"Handicapped Individual" means an individual (1) who has a physical or mental disability, (2) who has a substantial handicap to employment, and (3) who is expected to benefit in terms of employability from the provision of vocational rehabilitation services, or for whom an extended evaluation of rehabilitation is necessary to determine whether rehabilitation services will enhance his employability.

"Physical or Mental disability" means a physical or mental condition which materially limits, contributes to limiting, or, if not corrected, probably will result in limiting an individual's activities or functioning.

"Substantial Handicap to Employment" means that a physical or mental disability (in light of attendant medical, psychological, vocational, educational, and other related factors) impedes an individual's occupational performance, by preventing him from obtaining, retaining, or preparing for employment consistent with his capacities and abilities.

"Employability" refers to a determination that the provision of vocational rehabilitation services is likely to enable an individual to enter employment consistent with his capacities and abilities in the competitive labor market: the practice of a profession, self-employment, homemaking, farm or family work (including work for which payment is in kind rather than in cash), sheltered employment, homebound employment, or other gainful work.

"Severely handicapped individual" means a handicapped individual:

(1) who has a severe mental or physical disability which seriously limits his functional capacities (mobility, communication, self-care),

(2) whose vocational rehabilitation requires multiple vocational rehabilitation services over an extended period of time, and

(3) who has one or more physical or mental disabilities resulting from amputation, arthritis, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological

disorders (including stroke and epilepsy, paraplegia, quadriplegia, and other spinal cord conditions), and renal failure, or a disability or a combination of disabilities determined on the basis of an evaluation of rehabilitation potential to cause comparable substantial functional limitation.

The term also may include an individual who is a beneficiary of social security disability insurance benefits under Title II of the Social Security Act or a blind or disabled recipient of Supplemental Security Income under Title XVI of the Social Security Act.

SITES, STAFF, AND SOURCES

DVRS maintains offices throughout the State in Paterson, Hackensack, Jersey City, Newark, East Orange, Elizabeth, Morristown, Hackettstown, Trenton, Red Bank, Toms River, New Brunswick, Somerville, Atlantic City, Bridgeton, Woodbury, Camden, Willingboro, Pompton Lakes, and Cape May. Each prospective client is interviewed by a rehabilitation counselor. The counselors are the key persons in the process; they guide the individual through the process, and maintain contact with him. Available medical and other information is gathered, and additional examinations are arranged. Each office has a medical consultant, to whom prospective plans and problems are presented. Consultants are available for dental, psychiatric, and cardiovascular problems. Other consultations are obtained as needed. If medical or other therapy is indicated, such is obtained. The medical services are a part of the total service: counseling, training, job placement, and other needs are provided.

All services, including medical are arranged via prior authorization. DVRS is not Medicare, Medicaid, or an insurance company. It arranges for the provision of services to eligible individuals. There are budgetary restrictions, and we cannot pay usual and customary fees. We try to be equitable, but DVRS has always depended on the good offices of New Jersey physicians who have been willing to provide needed care to our clients. DVRS does not treat acute medical problems, and does not provide short-term rehabilitation.

This item was prepared by Daniel J. O'Regan, M.D., Medical Director, New Jersey Division of Vocational Rehabilitation Service. He may be addressed at the Department of Labor and Industry, P.O. Box 2098, Trenton, NJ 08625.

REFERRAL

If you feel that you have patients who may be eligible, get in touch with the DVRS office in your area. A list may be obtained by writing to the Division of Vocational Rehabilitation Services, Labor and Industry Building, P.O. Box 2098, Trenton, New Jersey 08625—(609) 292-5987. The local office manager will be glad to discuss policies and procedures.

The New Jersey Rehabilitation Act was a prototype for others in the nation. Pioneers like Drs. Fred H. Albee and Henry Kessler started the process in Colonia during the first World War. We have come a long way since then, and the field is still expanding; we invite your participation.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

Medical School-Community Hospital Affiliations as a Way of Achieving "Core" Medical Education in Clinical Disciplines

A major change in medical education occurring principally after World War II has been the increasing number of affiliations between medical schools (universities) and community hospitals. In many cases, the purpose has been the provision of "core" aspects of clinical teaching for medical students and house officers. A major justification has been a greater actual or alleged reality to the practice of medicine than that experienced in university hospitals where tertiary care is preeminent.

Although this justification is probably valid, the new arrangements are more likely a consequence of other profound changes in medical education and delivery of health care. These new associations have not been free of turbulence and rancor and have not been uniformly successful.

However, a recent review by a na-

tional committee has concluded that such affiliations can provide an effective response to contemporary challenges in provision of health services and medical education.¹ The report, entitled "University/Regional Partnership for Medical Education and Health Care," covers a review of four "successful" programs and concludes: "The programs, to a greater or lesser extent in all cases, have allowed for an increase in the total number of physicians being trained; have increased the proportion of trainees who have chosen to practice general internal medicine; have been influential in placing physicians in underserved areas; have contributed to making the community's professional environment more attractive by means of continuing medical educational programs; and . . . have improved patient services and, in the long run, hopefully will improve the health of people residing in the areas."

If all of these gains are demonstrable, one might ask why such affiliations were not a prominent part of the medical scene earlier and what the requisites are for success.

Prior to World War II, most universities were able to meet the educational needs of a more limited number of students and house officers through the use of university hospitals and/or city-county hospitals. Universities did not look much into the community, and community hospitals were used by them primarily for fourth-year electives. The electives were most frequently tutorial and the role of the teaching physician more central than the role of the hospital. Federal legislation, aimed largely at modifying health care, changed this system dramatically.

The 1965-66 Medicare-Medicaid legislation sounded the death knell of many large city hospitals and drastically modified the operation of most others. It eliminated "ward" services in university hospitals. Additional federal legislation led to an approximate doubling of medical student numbers. Thus the balance of educational need versus resource was upset rapidly. Other resources urgently were sought. Some of the imbalance was addressed by construction of Veterans Administration hospitals in close proximity to medical school complexes. This new symbiosis more or less neutralized the loss of city hospital resources but was inadequate for the new numbers of students.

Thus for the majority of schools the middle 60's brought the realization that a "core" relationship with a community hospital(s) was a matter of serious im-

port. For those schools lacking either adequate university hospitals or a neighboring VA hospital, the urgency of affiliation was especially great. For those very few new schools having neither, such as CMDNJ-Rutgers Medical School, such affiliations were crucial, and making them function suitably was tantamount to survival.

It was not surprising that medical schools, especially those in the Rutgers Medical School situation, came quickly to perceive the necessity of bringing a more generous commitment of their time, resources, and energy to the partnership. In response, certain hospital administrators, aided by new guidelines permitting inclusion of some educational activities in health care costs, also came to accept their new and greater responsibility as a cooperating partner in medical education. The short-lived Regional Medical Programs led to the further concept that new affiliations based on the needs of medical education could be expanded to include regionalization of all health-care and educational activities.

If Dr. Tarlov's¹ conclusions are correct about the abundant mutual advantages accruing to the partners of a successful affiliation, how do these partners assure success in an association born of the pressures of societal change? Perhaps because for Rutgers Medical School the necessities were greatest, we have been, in my mind, uncommonly successful in our initial efforts. Therefore I would like to share the important principles and tactics which I believe have been contributory to success.

The overriding guiding principle is commitment—psychologic, programmatic, and financial. The three are of course related, but the most important is probably the first, since it can sustain the other two. This commitment applies to trustees, administrators, and physicians alike. While Tarlov's¹ conclusion gives an objective base to the commitment, the faith of intuition and general experiences may be even more sustaining for trustees, especially in those years before objective outcomes can be demonstrated. The commitment by the administration and trustees, especially those representing the hospital, whether by experience or faith, largely determines the outcome. Many of the hospital physicians will have chosen earlier to escape the team approach and the financial arrangements of a university-hospital setting. They may be unsympathetic or even hostile to the introduction of an environment they previously

*Guest editor of the column this month is Hadley L. Conn, Jr., M.D., chairman of the department of medicine, CMDNJ-Rutgers Medical School.

¹Tarlov AR, Rice JA, et al, editors. *University/Regional Partnerships for Medical Education and Health Care: An Internal Medicine Perspective*. Chicago, The University of Chicago, 1979.

had chosen to leave, yet their cooperation is one vital ingredient of the program. Only an understanding administration can underwrite the cooperation of groups with divergent views and interests until such time as the mutual advantages become self-evident. In my experience, this difficult phase usually covers five and sometimes ten years, even though other programmatic needs are fulfilled.

For a department of medicine, the "core" educational program involves primarily teaching of student clerks and education of housestaff. Since these two groups can do much to educate each other through extended intimate contact, their participation should take the form of membership on an "attending" team. The general aspects of student education become a top priority of the PGY2 or PGY3 team member, while freeing the PGY1 for that teaching related to immediate patient care.

Since success depends much on the performance of the house officers, they should be a carefully selected group. Unless the hospital has an established record for house-officer recruitment, the house officers should be selected through the university as part of an integrated residency program.

A critical mass number of faculty is needed to provide intimate senior direction and to provide educational coverage in the usual disciplines composing a department of medicine. In medicine a minimum of eight or ten full-time equivalents is required. These may be geographic or true full-time physicians so long as they have adequate time for teaching interactions. This cadre must be supplemented by at least a small group of devoted voluntary faculty. Incidentally, a very useful device for sustaining the involvement of the latter is "piece-work" payment for student conferences and teaching rounds. Regular "rounding" and conference supervision by the university-based visiting faculty is a third substantial ingredient of the faculty input.

Faculty members should be chosen through the combined efforts of hospital and university, based on the same criteria for selection as other university faculty members. Any deviation should be in the direction of emphasizing excellence of health care and teaching at the expense of research, which in a community-based, affiliated hospital may be difficult to sustain at a suitable funding level.

The cost of achieving success is not small. Multiple funding sources must be

utilized. Creative administration must be employed. Here the guiding principle is significant financial contributions on the part of both university and hospital. Unwillingness on the part of either party calls into question their credibility and real interest. A suitable hospital budget for a successful department of medicine program may be expected to be in excess of \$500,000 per year without including house-officer stipends or faculty income supplements generated from consultative practice. Faculty practice is highly desirable not only for supplementation of salaries but also for maintenance of health-care skills and for providing specialty care to the area.

In practice, the medical school should provide not only some part of the budget of a true "core" affiliated program but also cooperate actively in helping the hospital to generate the remaining funds. House-officer stipends are at present usually chargeable to an educational component of the hospital per diem and therefore not a serious budgetary problem. Developing federal and state guidelines provides educational salary stipends for a limited number of faculty members supervising teaching and health care, so long as they are charging professional fees only for consultative care.

Income from performance and interpretation of special tests can become a highly significant part of a departmental budget. Faculty members in divisions of cardiology, pulmonary disease, gastroenterology, and infectious disease particularly are open to the mechanism of salary support. Traditional distribution of these funds usually has meant that they are lost to the internal program of the hospital, rather becoming individual, volunteer-faculty income. Redirection of these funds to full-time faculty in lieu of salary may not be an easy administrative task but in most situations must be accomplished. State, federal, and private grants to fund special clinical projects or research programs are still other legitimate sources of funds. It is important to realize that no one of these or other funding sources ever can be adequate but that the sum of several sources can be—that an annual scramble to meet those extensive needs will continue to be the order of the day. Faculty and administration of both parties must work together to pool their talents in this scramble.

Though the task is arduous and sometimes unpleasant, we are pleased to believe that the CMDNJ-Rutgers Medical School affiliated partners in this regional

health venture wish to continue to expand our initial successes, and that they believe the anticipated results well worth the price.

Special Opportunities for M.D.'s or D.O.'s at Saint Michael's Medical Center*

1. Part-time residency or specialty fellowships—no tuition
2. Shared-scheduled residency or fellowship—paid salary as per medical school scale
3. Law—no tuition
 - a. Tutorial and court room experience in medical legal affairs for medical residents
 - b. Combined medical residency and law school education
4. Preceptorship and mini-residency: an individualized program—tuition
 - a. Bronchoscopy for pulmonary physicians
 - b. Cardiology—update C.C.U., cardiac surgical care stress testing, cardiac isotopes, etc.
 - c. Emergency room
 - d. Outpatient medicine
 - e. Nosocomial epidemiology
 - f. I.C.U. intensive medicine

Saint Michael's Medical Center was one of the first hospitals in the United States to develop a part-time and shared-scheduled, highly individualized program for interns and residents (American Board of Internal Medicine approved). At first (over 12 years ago) the program was designed for women with marriage, pregnancy, and children restrictions. Now the program has been expanded to all. More than ten physicians—M.D.'s and D.O.'s from New Jersey—have taken advantage of this offer. Physicians in practice have returned to training for updating or to qualify for the Boards of Internal Medicine. Others have chosen this program for economic and physical reasons.

In addition to the part-time program for which there is no salary, Saint Michael's Medical Center has a shared residency where two residents divide one salaried position. Generally, each resi-

*This item was prepared by Leon G. Smith, M.D., Director, Department of Medicine, Saint Michael's Medical Center, Newark 07102.

dent rotates every six months in training and the other six months works in practice, industry, or research. Saint Michael's Medical Center and associated industries in Newark help find good salaried positions for these physicians. Locum tenens are often available by New Jersey physicians. Saint Michael's Medical Center also has coordinated this program for physicians who wish to pursue a law profession as well. The special program in law is available as an elective for medical residents at Saint Michael's Medical Center whereby they follow a liability case in process from beginning to end—"A relationship with a defendant lawyer."

On the other hand, Saint Michael's Medical Center works in concert with the law schools in the area allowing our medical residents a special program for those who are accepted for law school. Hence one can complete a law degree and Internal Medicine Board requirements simultaneously.

Preceptorships and mini-residencies are available on a limited basis for a given period of time in the fields listed in the outline.

Thus to meet the changes in our society, individual aspirations, and inflationary spirals, Saint Michael's Medical Center cordially invites all applicants to send a curriculum vitae and proposed plan to Dr. Leon Smith, Director of Medicine, Saint Michael's Medical Center, Newark, New Jersey 07102. No phone calls please.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them

ALLERGY—Douglas C. Wiseman, D.O., TH264 Pine Run, Blackwood 08012. College of Osteopathic Medicine, Kansas City (1974). Also general internal medicine. Board eligible (IM). Solo, group, partnership. Available.

Richard W. Huss, M.D., 555 Graham Rd., Fort Sam Houston, TX 78234. CMDNJ 1973. Subspecialty, immunology. Board certified. Group, partnership, solo. Available October 1979.

ANESTHESIOLOGY—June Hyung Rim, M.D., 11 Park Avenue, Apt. 3-0, Mt. Vernon, NY 10550. Seoul (Korea) 1973. Board eligible. Partnership, solo, group. Available.

Andrew Chih-Kang Cheng, M.D., 435 East 70th Street, Apt. 22-F, New York, NY 10021. Peking (China) 1962. Board eligible. Group, partnership, solo, administrative, research, or academic. Available.

Romeo Yangco Sembrano, M.B., Herbert J. Thomas Memorial Hospital, South Charleston, WV 25309. Santo Tomas (Philippines) 1962. Also general family practice. Board eligible. Solo, emergency room, partnership. Available.

Barry M. Baylis, M.D., 2130 Williamsbridge Road, Bronx, NY 10461. Wisconsin 1971. Board eligible. Partnership, group, solo. Available.

Raveendra Vithal Limaye, M.D., 335-D Third Avenue, Long Branch 07740. Baroda (India) 1972. Board eligible. Partnership, single or multispecialty group, institutional. Available September 1979.

Tulsiram Gowlikar, M.D., 2951 S. King Drive, Apt. 1009, Chicago, IL 60616. Gandhi (India) 1972. Board eligible. Solo, partnership, single-specialty group. Available.

Kiritkumar Sheth, M.D., 2851 S. King Drive, Apt. 1117, Chicago, IL 60616. Baroda (India) 1972. Special interest, family practice. Board eligible. Partnership, solo, public health. Available.

Hector R. Felbarg, M.D., 12 Kingsley Road, Huntington, New York 11743. Cordoba (Argentina) 1957. Board certified. Fee for service. Available.

CARDIOLOGY—Lee M. Krause, D.O., 239 Brydon Road, Philadelphia, PA 19151. Phila. College of Osteopathy 1975. Also general internal medicine. Board eligible. Solo, group, partnership. Available July 1980.

Thomas J. Maley, M.D., 2525 South Boulevard, Idaho Falls, ID 83401. CMDNJ 1970. Also general internal medicine. Board certified (both). Group or partnership, prefer hospital-based. Available.

CARDIOVASCULAR DISEASES—Bulent Dincer, M.D., 270 Henderson St., Apt. 6-F, Jersey City 07302. Hacettepe University, Ankara (Turkey) 1972. Also general internal medicine. Board eligible (IM). Research, academic, or multi-specialty group. Available.

Chi-Kwong Iai, M.D., Deborah Heart & Lung Center, Browns Mills 08015. National Defense Medical Center (Taiwan) 1972. Also general internal medicine. Board certified (IM). Single or multi-specialty, group, institutional. Available.

Mylapanahalli Sanathanamurthy, M.D., 905 Pine Avenue, Apt. 13, Redlands, CA 92373. Bangalore (India) 1971. Also general internal medicine. Board eligible (IM). Multi- or single specialty group, institutional. Available.

Bhagwan Dass Gupta, M.D., 4671 Dalebridge Road, Apt. 412, Warrensville Heights, OH 44128. All India Institute of Medical Science 1973. Also general internal medicine. Single or multi-specialty group, solo. Available.

Roger Neiss Zitrin, M.D., Micieli Place, Brooklyn, NY 11218. Rutgers, 1974. Also general internal medicine. Board eligible (IM). Solo, single or multi-specialty group. Available September 1979.

David H. White, M.D., 4119 Flint Hill, San Antonio, TX 78230. University of Texas 1972. Also general internal medicine. Board certified (IM). Institutional, single or multi-specialty group, partnership. Available.

Soma Narshiah Pulipati, M.D., 725 East Main Street, Kings Park, NY 11754. Osmania (India) 1971. Also general internal medicine. Board certified (IM). Solo, partnership, group. Available.

Vijay G. Mistry, M.D., 203 Fair Hill Towers, 12000 Fair Hill Road, Cleveland, OH 44120. T.N. Medical (India) 1973. Also general internal medicine. Board eligible (IM). Single or multi-specialty group, partnership. Available.

Sabba Rao Chennupati, M.D. 407 Lindsay Court #12, Louisville, KY 40206. Rangaraya (India) 1970. Board eligible. Group, partnership, solo. Available.

Narayanaiyengar R. Devaraj, M.D., 2851 S. King Drive, Apt. 814, Chicago, IL 60616. Mysore (India) 1973. Also general internal medicine. Board certified (IM). Board eligible. Institutional, single or multi-specialty group. Available.

Naresh K. Pruthi, M.D., 2600 44th Avenue, Apt. 1, San Francisco, CA 94116. All India Medical Institute 1973. Also general internal medicine. Board certified (IM). Solo, partnership, group. Available.

Nagorao V. Karhade, M.D., 1926 W. Harrison Street, Apt. 1804, Chicago, IL 60612. Aurangabad (India) 1970. Also general internal medicine. Board certified (IM). Board eligible. Solo, partnership, group. Available.

Dhirendra Mohan, M.D., 757 Main Street, Apt. 30, South Portland, ME 04106. King George (India) 1968. Also general internal medicine. Board certified (IM). Board eligible. Solo, industrial, emergency room. Available.

Brojesh C. Pakrashi, M.D. Medical Center, Morgantown, WV 26506. Medical College of Calcutta (India) 1958. Also general internal medicine. Board eligible (IM). Research, academic, institutional. Available.

DERMATOLOGY—Sam Stieglitz, M.D., 26151 Lakeshore Blvd., Apt. 2115, Euclid, OH 44132. McGill (Canada) 1971. Also general internal medicine. Board certified (IM). Solo, partnership, single specialty group. Available.

David R. Benjamin, M.D., 2911 Stonecliffe Drive, Pittsburgh, PA 15146. Pittsburgh 1974. Also general internal medicine. Board certified (IM). Multi-specialty group, solo, partnership. Available.

EMERGENCY MEDICINE—Jose S. Encanto, M.D., 89-06 135th Street, Apt. 7-J, Richmond Hill, NY 11418. Santo Tomas (Philippines) 1971. Special interest, clinical pathology. Board eligible (CP). Emergency room, institutional, multi-specialty group. Available.

ENDOCRINOLOGY—Ranjan P. Shah, M.D., 6120 Bellaire Boulevard, Apt. 812,

Houston, TX 77081. University of Bombay (India) 1968. Also general internal medicine. Board eligible (IM). Any type practice. Available.

Subramanyam K. Naidu, M.D., 1408-F Druid Valley Drive, Atlanta, GA 30329. S.V. University (India) 1971. Also general internal medicine. Board eligible (IM). Solo, institutional, partnership. Available.

Bruce J. Shickmanter, M.D., 401 East 88th Street, Apt. 11-E, New York, NY 10028. Upstate Medical Center (NY) 1974. Also general internal medicine. Board certified (IM). Board eligible. Single or multi-specialty group, partnership. Available.

FAMILY PRACTICE—John Schifferdecker, M.D., 52-08 69th Street, Maspeth, NY 11378. Mount Sinai, New York 1976. Board eligible. Partnership, single or multi-specialty group. Available.

Mark J. Decker, M.D., 115 Newbrook Lane, Bay Shore, NY 11706. Georgetown 1975. Board certified. Single specialty group, partnership, solo. Available.

Kirit D. Trivedi, M.D., 546 West Ridgeway Street, Warrington, NC 27589. Baroda (India) 1965. Special interest, emergency medicine. Board certified (general surgery). Single specialty group, solo, partnership. Available.

Chik S. Chin, M.D., 21 Walnut Road, Apt. 1-1A, Glen Cove, NY 11542. Taiwan 1974. Board eligible. Single or multi-specialty group, institutional, partnership, solo, emergency room, school health. Available.

Romeo Y. Sembrano, M.D., Herbert J. Thomas Memorial Hospital, South Charleston, WV 25309. Santo Tomas (Philippines) 1962. Special interest, anesthesiology. Board eligible. Solo, emergency room, partnership. Available.

Mark H. Krotowski, M.D., 7-29 Hegeman Avenue, Apt. 3-H, Brooklyn, NY 11212. Tel Aviv (Israel) 1976. Board eligible. Partnership, single or multi-specialty group. Available.

Padmini Thakkar, M.D., 1055 Mayfield Lane, Hoffman Estates, IL 60195. J.N. Medical School (India) 1975. Board eligible. Partnership, solo, institutional. Available.

Gudimetla V.S. Reddy, M.D., 6 Locust Court, Hollidaysburg Manor Apts., Hollidaysburg, PA 16648. Andhra Medical (India) 1973. Board eligible. Single or multi-specialty group, institutional. Available.

GASTROENTEROLOGY—Eva I. Vidins, M.D., 237 Highland Avenue, Warwick, RI 02886. Toronto 1966. Also general internal medicine. Board certified (GP). Board eligible. Single or multi-specialty group, solo. Available.

Steven J. Nussbaum, M.D., 891 Clopper Road, Apt. B-1, Gaithersburg, MD 20760. SUNY-Downstate 1974. Also general internal medicine. Board certified (IM). Board eligible. Single or multi-specialty group, partnership. Available.

Mark T. Birns, M.D., 6630 SW Capitol Highway, Apt. 4, Portland, OR 97219. Einstein 1974. Also general internal medicine. Board certified (IM). Research, institutional, emergency room. Available September 1979.

Miguel A. Sarriera, M.D., Hospital Regional de Bayamon, Avenue Laurel Santa Juanita, Bayamon, PR 00619. Barcelona (Spain) 1960. Also general internal medicine. Board eligible (IM). Institutional, research, emergency room. Available.

GENERAL PRACTICE—Babulal B. Dudani, M.D., 1716 Bath Road, Apt. G-8, Bristol, PA 19007. Baroda (India) 1967. Emergency room, partnership, multi-specialty group. Available.

Khun Y. Son, M.D., 2649 Arlington Drive, Apt. 202, Alexandria, VA 22306. Catholic Medical School (Korea) 1972. Solo, multi-specialty group, partnership. Available.

Sam W. Law, M.D., 60 Eldridge Street, Apt. 6, New York, NY 10002. National University (Taiwan) 1970. Group, partnership, solo. Available.

HEMATOLOGY—Janaki Giri, M.D., 357 Morris Street, Apt. 15, Albany, NY 12208. Jipmer (India) 1964. Also general internal medicine. Board eligible. Institutional, single or multi-specialty group. Available.

Charles A. Masor, M.D., 3 Mountain Way South, West Orange 07052. NYU 1974. Also general internal medicine. Board eligible (IM). Partnership, single or multi-specialty group. Available.

INFECTIOUS DISEASES—Nirmal K. Fernando, M.D., Lionel Village, Apt. P-5, North Brunswick 08902. University of Ceylon (Sri Lanka) 1970. Also general internal medicine. Board certified (IM). Multi-specialty group, institutional, partnership. Available.

INTERNAL MEDICINE—Peter Y. Lee, M.D., 319 East 24th Street, Apt. 21-D, New York, NY 10010. NYU 1974. Subspecialty, pulmonary diseases. Board certified. Single or multi-specialty group, partnership. Available.

T.S. Dharmarajan, M.D., 3990 Bronx Boulevard, Apt. 3-M, Bronx, NY 10466. Trivandrum (India) 1967. Subspecialty, nephrology. Board certified. Partnership, multi-specialty group, solo. Available August 1979.

Daniel C. Monahan, M.D., 28-4A Mt. Pleasant Village, Morris Plains 07950. CMDNJ 1976. Board eligible. Partnership, single or multi-specialty group. Available.

Pulivarti Bapurao, M.D., 199 F Howard Drive, Bergenfield 07621. Guntur (India) 1971. Subspecialty, nephrology. Board eligible. Solo, partnership, multi-specialty group. Available.

Vijayalakshmi Chakmakura, M.D., St. Peter's Medical Center, New Brunswick 08903. Guntur (India) 1971. Board eligible. Institutional, public health, industrial. Available.

Madhavan R. Sasikumar, M.D., 125 Schroeders Avenue, Apt. 11-B, Brooklyn, NY 11239. Trivandrum (India) 1967. Institutional, multi-specialty group, emergency room. Available.

Stephen A. Atlas, M.D., 159 Hawthorne Avenue, Apt. 262, Central Islip, NY 11722. Wisconsin 1976. Board eligible. Partnership, multi-specialty group, institutional. Available.

Sambandam Baskaran, M.D., 2 Korado Court, Apt. 3-A Baltimore, MD 21207. Stanley (India) 1970. Board eligible. Partnership, multi-specialty group, institutional. Available.

Joo-Sock Yang, M.D., 7-15 162nd Street, Apt. 3-A, Whitestone, NY 11357. Seoul (Korea) 1971. Board eligible. Institutional, partnership, solo. Available.

Taha Hamoui, M.D., 9831 Timberwood Circle, Louisville, KY 40223. Damascus (Syria) 1972. Subspecialty, nephrology. Board certified. Any type practice. Available.

D. William Klasco, M.D., 30 Waterside Plaza, New York, NY 10010. Downstate 1974. Subspecialty, neurology. Board eligible. Industrial, emergency room, institutional. Available.

Ravindra K. Goyal, M.D., 78-40 164th Street, Apt. 4-D, Flushing, NY 11366. S.M.S. Medical College (India) 1972. Subspecialty, pulmonary diseases. Board eligible. Institutional, solo, multi-specialty group. Available.

Jose M. Amparo, M.D., R.D. 4, Thompson Road, Webster, MA 01570. Far Eastern (Philippines) 1967. Special interest, family medicine. Board eligible. Solo, partnership, emergency room. Available.

Ashok K. Shetty, M.D., 552 Amberson Plaza, Pittsburgh, PA 15213. Government Medical College (Mysore, India) 1970. Board eligible. Solo, partnership, single-specialty group. Available October 1979.

Mahmoodul H. Yekta, M.D., 227 Wintonbury Ave., Apt. #4, Bloomfield, CT 06002. Darbhanga (India) 1964. Subspecialty, pulmonary diseases. Board eligible. Multi-specialty group, solo, institutional. Available.

Abziz H. Junagadhwala, M.D., 9 Nixon Court, Apt. 3-J, Brooklyn, NY 11223. Grant Medical (India) 1969. Subspecialty, pulmonary diseases. Board eligible. Partnership, single or multi-specialty group, solo, institutional. Available.

Bahoobal Kumar, M.D., 1125 Schroeders Avenue, Apt. 7-G, Brooklyn, NY 11239. Gandhi Medical (India) 1961. Subspecialty, cardiovascular diseases. Board eligible. Multi-specialty group, institutional, partnership. Available.

Jaffer J. Khan, M.D., 638 22nd Street West, Bayonne. King Edward (Pakistan) 1969. Subspecialty, gastroenterology. Board eligible. Solo, multi-specialty group, single specialty group. Available.

Mohammad S. Anwar, M.D., 194-01A 64th Circle, Apt. 1-C, Fresh Meadows, NY 11365. Liaquat Medical College (Pakistan) 1968. Board eligible. Solo, multi-specialty group, institutional. Available.

Franciska G. Katona, M.D., Village Lane, Apt. Oak 2, Abington, PA 19001. Temple 1976. Special interest, occupational medicine. Board eligible. Industrial, academic, administrative. Available.

Anthony E. Niescier, D.O., 3106 Aspen Circle, Norristown, PA 19401. Phila. College of Osteopathic Medicine 1975. Special interest, family medicine. Single-specialty group, partnership, multi-specialty group. Available.

Chimanlal J. Patel, M.D., 89-06 135th Street, Apt. 6-A, Jamaica, NY 11418. Dr. V.M. Medical (India) 1971. Special in-

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terest, general medicine. Board eligible. Single or multi-specialty group, institutional. Available.

Devi P. Misra, M.D., 7K University Terrace, Columbia, MO 65201. S.C.B. Medical School (India) 1969. Subspecialty, pulmonary disease. Board certified. Solo, multi-specialty group, institutional. Available September 1979.

Silvestra Almirol, M.D., 234 Mass Avenue, Valley Cottage, Bronx, NY 10989. University of the East (Philippines) 1968. Subspecialty, neurology. Board eligible. Solo, multi-specialty group, institutional. Available.

Ravi K. Malpam, M.D., 1165 Rt. 22, Apt. 22, North Plainfield 07061. Osmania (India) 1972. Subspecialty, pulmonary diseases. Board eligible. Institutional, solo, or multi-specialty group. Available.

Pedro A. Rodriguez-Paiva, M.D., 2160 Matthews Ave., Apt. 6-M, Bronx, NY 10462. San Marcos (Peru) 1971. Board eligible. Single or multi-specialty group, institutional. Available.

Mayank Y. Doshi, M.D., 520 Desplaines Ave., Apt. 303, Forest Park, IL 60130. Seth G.S. Medical (India) 1970. Subspecialty, endocrinology. Board certified. Partnership, single or multi-specialty group. Available.

Muhammad G. R. Shaikh, M.D., 190-06A 69th Avenue, Flushing, NY 11365. Dacca (East Pakistan) 1964. Board eligible. Solo, partnership, single-specialty group. Available.

Muhammad Tayyab, M.D., 2112 Starling Ave., Apt. 4-L, Bronx, NY 10462. King Edward (Pakistan) 1972. Board eligible. Solo, institutional, multi-specialty group. Available.

Josef H. Hertz, M.D., 840 E. 8th St., Brooklyn, NY 11230. Univ. of Bologna (Italy) 1974. Board eligible. Any type of practice. Available September 1979.

Chi-Pui Cheung, M.D., 2974 20 Lane, Apt. 3G, Brooklyn, NY 11214. National Med. (Taiwan) 1969. Subspecialties, hematology, oncology. Board certified. Solo. Available.

Soma N. Palipati, M.D., 725 East Main Street, Kings Park, NY 11754. Osmania (India) 1971. Subspecialty, cardiology. Board certified. Solo, group, partnership (in that order). Available.

Richard E. Handelsman, D.O., 40 Prospect Avenue, Apt. 3-M, Bldg. 1, Norwalk, CT 06850. College of Osteopathic Medicine & Surgery 1976. Group or partnership. Available August 1980.

Charles F. McNally, M.D., Box 1774, 61 Moulton Road, Duxbury, Massachusetts 02332. New York Medical College 1968. Board certified. Group or partnership. Available.

Carol D. Silver, M.D., 1619 Third Avenue, Apt. 4-G, New York, NY 10028. Duke 1970. Subspecialty, medical oncology. Board certified. Solo, group, or partnership. Available.

Kamran Hassidim, M.D., 4303 Caminito Del Zafiro, San Diego, CA 92121. Tehran (Iran) 1971. Subspecialties, hematology, oncology. Board eligible. Any type practice. Available.

Martin S. Lerman, M.D., 3307 Can-

nongate Road, Apt. 10, Fairfax, VA 22031. Georgetown 1973. Board certified. Any type practice. Available September 1979.

Stuart H. Packer, M.D., 3406 Denise Street, Durham, NC 22704. SUNY-Downstate 1974. Special interest hematology/oncology. Board certified. Group or partnership. Available July 1980.

Nanda K. S. Iyengar, M.D., 185 Ardsley Loop, Apt. 17-D, Brooklyn, New York 11239. Mysore (India) 1971. Special interest, cardiology. Any type practice. Available September 1979.

NEPHROLOGY—Bassam M. Haddad, M.D. 725 Scotland Road, Orange 07050. Damascus, (Syria) 1972. Also general internal medicine. Board eligible. Single or multi-specialty group, solo. Available.

Rafael A. Javier, M.D., 1350 West Bethune, Apt. 1603, Detroit, MI 48202. Univ. of the Philippines 1972. Also general internal medicine. Board certified (IM). Single specialty group, partnership, solo. Available.

Jeevanandhan Rajaratnam, M.D., 1227 South Harlem Avenue, Apt. 306, Berwyn, IL 60402. Madurai (India) 1973. Also general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available.

NEUROLOGY—Shashi A. Husain, M.D., 325 North 15th Street, Apt. 1012, Philadelphia, PA 19102. All India Institute 1968. Board eligible. Single or multi-specialty group, research, partnership. Available.

Gerald P. Durkan, M.D., 5852 Phillips Avenue, Pittsburgh, PA 15217. Jefferson 1975. Subspecialty, emergency medicine. Board eligible. Single or multi-specialty group, partnership. Available July 1980.

Leroy J. Pelicci, M.D., P.O. Box 1357, Hershey, PA 17033. Pennsylvania State Univ. 1975. Special interest, psychiatry. Partnership, single or multi-specialty group. Available July 1980.

Peter Greco, M.D., 2100 Foxhall Rd., Washington, D.C. 20007. Georgetown 1976. Board eligible. Group or partnership. Available July 1980.

NUCLEAR MEDICINE—David B. Plone, D.O., 533 Northlake Boulevard, North Palm Beach, FL 33408. Phila. Coll. of Osteopathy 1968. Subspecialty, radiology. Board certified. Single specialty group, partnership, institutional. Available July 1980.

OBSTETRICS/GYNECOLOGY—Jeng Y. Lin, M.D., 945 Harvest Lane, Indiana, PA 15701. China Medical College (Taiwan) 1968. Also general practice. Board eligible. Multi-specialty group, solo, or school health. Available.

Hooshang A. Amiri, M.D., 1100 Carson Drive, Huntingtown, MD 20639. Isfahan (Iran) 1965. Board certified. Solo. Available.

Jerome B. Goldstein, M.D., 6675 E. Heritage Place South Englewood, CO 80111. Texas 1976. Any type practice. Available July 1980.

Promila Mathur, M.D., 15 First Street, Apt. 8-D, Hackensack 07601. S.N. Medical (India) 1965. Board eligible. Institutional,

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single or multi-specialty group. Available. Raymond Y. Fares, M.D., 1016 Lexington Avenue, New York, NY 10021. Alexandria (Egypt) 1962. Subspecialty, pathology. Board eligible. Any type practice. Available.

Chau-Kuang Lin, M.D., Route 224 R.D., Montour Falls, NY 14865. Kaohsiung (Taiwan) 1967. Board eligible. Single-specialty group, partnership, solo. Available.

Heinz O. Osterholzer, M.D., PSC 451, K.I. Sawyer AFB, Michigan 49843. Hahnemann 1968. Board eligible. Group or partnership. Available June 1980.

Richard J. Malafy, M.D., Box 31, Frankstown Road, Hollidaysburg, PA 16648. CMDNJ 1971. Board eligible. Group or partnership. Available.

ONCOLOGY—Ravi C. Khanna, M.D., 4962 Willoway Court East, Columbus, OH 43220. Amritsar (India) 1971. Also general internal medicine. Board certified (IM). Single-specialty group, partnership, solo. Available.

Pradeep S. Mahal, M.D., 12415 Newbrook Drive, Houston, TX 77072. All India 1974. Also general internal medicine. Board certified (IM). Solo, multi-specialty group, research. Available July 1980.

Enrico C. Sobong, M.D., 130 Gale Boulevard, Apt. 102, Melvindale, MI 48122. Also general internal medicine. Board certified (IM). Solo, partnership, single or multi-specialty group, institutional. Available.

OPHTHALMOLOGY—Cary H. Freeman, M.D., 2309 West Broadway, Apt. 315, Columbia, MO 65201. Howard University 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Kenneth H. Zaslow, M.D., 20 Dykeman Road, Delmar, NY 12054. Albany 1973. Board certified. Single or multi-specialty group, partnership. Available.

Alan D. Gordon, M.D., 3230 Hayden Street, Sayre, PA 18840. CMDNJ 1974. Multi-specialty group, partnership, solo. Available July 1980.

Sam Katzurin, M.D., 258 Middle Neck Road, Great Neck, NY 11021. University of Bologna (Italy) 1973. Board eligible. Solo, partnership, multi-specialty group. Available.

Donald S. Gerber, M.D., 510 Second Avenue, Apt. 11-F, New York, NY 10016. Stanford 1975. Board eligible. Partnership, single-specialty group, solo. Available.

Wilma K. Brucker, M.D., 669-7 Willow Bend Drive, Clarkson, GA 30021. Med. College of PA 1972. Board certified. Solo, multi-specialty group, ophthalmology group, or academic (not in large urban area). Available December 1979.

OTORHINOLARYNGOLOGY—Sultan F. Khan, M.D., 7 Seward Street, Dansville, NY 14437. King Edward (Pakistan) 1969. Board certified. Solo, partnership. Available October 1979.

Steven R. Chesnick, M.D., 50 Wyman St., Newton, MA 02168. Pittsburgh 1974. Board eligible. Single specialty group, partnership, multiple specialty group. Available.

PATHOLOGY—A.H. Rao, M.D., 83-30 Vietor Ave., Apt. 201, Elmhurst, NY 11373. Gandhi (India) 1973. Board eligible. Partnership, institution, single specialty group. Available.

Marc G. Yagore, III, 6140 Edsall Rd., Alexandria, VA 22304. Univ. of Philippines 1972. Board certified. Institution, multi-specialty group, research, academic, administrative. Available.

Irwin J. Hollander, M.D., 2735 E. Country Club Rd., Philadelphia, PA 19131. Jefferson 1972. Board eligible. Institution, research, single specialty. Available.

Juan A. Suriel, M.D., 6 Dalecrest Court, Timonium, MD 21093. Univ. Santo Domingo 1971. Board eligible. Single or multi-specialty group, partnership, public health, research. Available.

Kong L. Tan, M.D., 338 High St., Perth Amboy, NJ 08861. Malang 1970. Board eligible. Partnership, institutional, multi-specialty group. Available.

Jose S. Encanto, M.D., 89-06 135th St., Richmond Hill, NY 11418. Univ. Santo Tomas (Philippines) 1971. Board eligible. Institution, multi-specialty group. Available.

V. A. Kagali, M.D., 54 Denby Acres, 7426 Henry Clay, Liverpool, NY 13088. Bangalore (India) 1971. Board certified. Multi-specialty group, partnership, institution. Available.

Punita P. Kothari, MD.D., 5990 Henry Avenue, Apt. 4, Philadelphia, PA 19128. M. P. Shah (India) 1969. Board eligible. Associate, group, partnership, institution. Available July 1979.

PEDIATRICS—S. R. Nanvati, M.D., 1945 Corlies Ave., Neptune, NJ 07753. B J Medical (India) 1970. Board eligible. Single specialty group, institution, solo. Available.

A. A. Vora, M.D., 63-43 Austin St., #1A, New York City 11374. All India University (India) 1962. Board eligible. Partnership, multi-specialty group, single specialty group, emergency room. Available.

Bernard Samtoy, M.D., 4634-B West Montague Ave., Charleston Hts., SC 29405. Montpellier (France) 1973. Board eligible. Single specialty group, partnership. Available August 1979.

R. K. Osei, M.D., 4000 Wilder Ave., Bronx, NY 10466. Ghana Med (Ghana) 1972. Institution, emergency room, single or multi-specialty group. Available.

R. B. Vasa, M.D., 321 East 13th St., New York City 10003. Baroda Faculty of Med (India) 1968. Board certified. Single specialty group, institution partnership. Available.

Yoon-Taek Chun, M.D., 1401 E. Hyde Park Blvd, Chicago 60615. Yonsei Univ (Korea) 1972. Board eligible. Single or multi-specialty group, partnership, solo. Available.

T. G. Thanjan, M.D., 3103 Fairfield Ave., Apt. 9K, New York City 10463. Med Col Kerala (India) 1973. Board eligible. Partnership, single or multi-specialty group. Available August 1979.

Kusum Kumar, M.D., 125 Schroeder's Ave., Brooklyn, NY 11239. Gandhi Medical (India) 1962. Board eligible. Institu-

tion, multi-specialty group, partnership. Available.

D. J. Karnik, M.D., 26 Koster Blvd., Edison, NJ 08817. Grant Med (India) 1971. Board eligible. Partnership, single or multi-specialty group. Available.

N. R. Thotakura, M.D., 10 Overlook Rd., Apt. 6B, Summit, NJ 07901. Rangaraya Med (India) 1973. Board eligible. Multi-specialty group, single specialty group, partnership. Available.

B. W. Lee, M.D., 1160 Midland Ave., Apt. 8M, Bronxville, NY 10708. Yonsei Univ (Korea) 1973. Institution, single specialty group, partnership, multi-specialty, emergency room. Available.

S. A. Bharani, M.D., 21438 Dequindre St., Apt. 101, Warren, MI 48091. Baroda (India) 1976. Partnership, public health, solo, emergency room, single-specialty group. Available July 1980.

Eugene M. Shatz, M.D., Frankfurt Military Complex, Box 55, APO, NY 09710. Temple 1971. Board certified. Single or multi-specialty group, school health. Available July 1980.

L. N. Gajula, M.D., 3318 Borden Apts., Third Avenue, Long Branch 07740. Osmania (India) 1970. Board eligible. Group, partnership, solo. Available.

Suryakumar Rajaram, M.D., 24 Wendy Lane, Charleston, SC 29407. Stanley Medical (India) 1969. Single specialty group, partnership, solo. Board eligible. Available January 1981.

Yousef Mardmomen, M.D., 113 Paulison Ave., Apt. K1, Passaic, NJ 07055. National Univ (Iran) 1972. Solo, multi-specialty group, academic. Available.

David I. Stolzenberg, M.D., 264-16 74th Avenue, Floral Park, NY 11004. Louvain (Belgium) 1976. Board eligible. Single or multi-specialty group, partnership. Available.

H. G. Tank, M.D., 111-28 66th St., Apt. 28, Forest Hills, NY 11375 MPS Med (India) 1974. Board eligible. Multi-specialty group, partnership, emergency room. Available.

M. Y. Najam, M.D., 4617 Shea Parkway, Corpus Christi, TX 78413. King Edward Med. (Pakistan) 1974. Board eligible. Partnership, Single specialty group, multi-specialty group. Available.

H. G. Levine, M.D., 2426 Lurting Ave., Bronx, NY 10469. Einstein, 1975. Board eligible. Single specialty, group, partnership. Available.

S. A. Rao, M.D., 950 49th St., Apt. 2G, Brooklyn, NY 11219. Bellary Med (India) 1974. Board eligible. Institutional, multi-specialty group, academic. Available.

PHYSICAL MEDICINE/REHABILITATION—Sonthineni Govardhan, M.D., 80-15 41st Avenue, Apt. 340, Elmhurst, NY 11373. Guntur (India) 1972. Board eligible. Multi-specialty group, partnership, institutional. Available.

PSYCHIATRY—Leroy J. Pelicci, M.D., P.O. Box 1357, Hershey, PA 17033. Pennsylvania State 1975. Partnership, single or multi-specialty group. Available July 1980.

Datla S. Raju, M.D., P.O. Box 1453, Monmouth Avenue, Middletown, NY

10940. Rangaraya (India) 1970. Board eligible. Single or multi-specialty group, partnership. Available.

Willy Krauss, M.D., 2907 Townway, Danville, IL 61832. Hadasah (Israel) 1965. Board eligible. Single or multi-specialty group, partnership. Available.

PULMONARY DISEASES—Saroj Sehgal, M.D., 299 South Harrison Street, Apt. 3-C, East Orange 07018. Maulana Alad (India) 1972. Subspecialty, internal medicine. Board eligible (IM). Multi-specialty group, institutional, solo. Available.

RADIOLOGY—Anil G. Desai, M.D., 701 Red Bank Avenue, Apt. G-10, West Deptford 08096. Baroda (India) 1972. Special interests—diagnostic radiology and nuclear medicine. Board eligible. Partnership, single-specialty institution. Available.

R. Murty Krishnamsetty, M.D., 101 West 15th Street, Apt. 4-E North, New York, NY 10011. Banaras (India) 1971. Special interests—therapeutic radiology and nuclear medicine. Board certified. Research, institutional, multi-specialty group. Available.

Cyril Milunsky, M.D., 8 Old Colony Lane, Apt. 1, Arlington, MA 02174. Witwatersrand (South Africa) 1969. Board certified (diagnostic radiology). Single or multi-specialty group, partnership. Available.

Robert Baran, M.D., 31 Crest Lake Drive, Oak Ridge 07438. SUNY 1972. Board certified. Hospital or office-based group in northern New Jersey. Available.

RHEUMATOLOGY—Alan B. Fishman, M.D., 70 Centre Street, Apt. 2-D, Brookline, MA 02146. Subspecialty, internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available.

SURGERY, CARDIOVASCULAR—Cesar P. Veluz, M.D., 1200 North State Street, Box 1930, L.A. County USC Medical Center, Los Angeles, CA 90033. University of the Philippines 1971. Special interest, thoracic surgery. Board eligible (general surgery). Single or multi-specialty group, partnership. Available.

Naweed K. Majid, M.D., Box 85, USAF Hospital, USAF, APO NY 09220. King Edward (Pakistan) 1967. Special interest, thoracic surgery. Board certified (general surgery). Single or multi-specialty group, institutional. Available July 1980.

Peter Y. Chang, M.D., 3450 Wayne Avenue, Apt. 26-J, Bronx, NY 10467. Taipei (Taiwan) 1970. Special interest, general surgery. Board certified (general surgery). Any type practice. Available.

S. A. Paruk, M.D., 3131 Whitethorn Road, Cleveland Heights, OH 44118. Natal (South Africa) 1970. Special interest in thoracic and general surgery, transplantation. Board certified (general surg.) Group, academic, solo. Available July 1980.

SURGERY, GENERAL—Jong Chun Moon, M.D., 420 Stockholm Street, Apt. B-6, Brooklyn, NY 11237. Kyungbuk (Korea) 1968. Board eligible. Partnership, solo, multi-specialty group. Available.

Richard A. Dietrich, M.D., 2205 Madison Road, Cincinnati, OH 45208. Cincinnati 1972. Board eligible. Single-specialty group, partnership, solo. Available.

Ibibama E. Afonya, M.D., 5 Fairview Terrace, East Green Bush, NY 12061. Ibadan (Nigeria) 1970. Board certified. Partnership, single or multi-specialty group. Available July 1980.

Kautilya A. Mehta, M.D., 6 Ashwood Court, Summit 07901. G. S. Medical College (India) 1967. Board eligible. Partnership, single specialty group, research. Available.

Luke J. Sheu, M.D., 2975 1/2 Northview Drive, Youngstown, OH 44504. Chung Shan (Taiwan) 1971. Special interest, emergency medicine. Board eligible. Partnership, multi-specialty group, emergency room. Available.

Ronald I. Lebman, M.D., 2300 Walnut St., Apt. 317, Philadelphia, PA 19103. Temple 1974. Board eligible. Partnership, single or multi-specialty group. Available.

Govindan Gandhi, M.D., 80 Guion Place, Apt. 12-P, New Rochelle, NY 10802. Thanjavur (India) 1973. Board eligible. Partnership, single specialty group, solo. Available.

Bose S. Mikkilineni, M.D., 555 Prospect Place, Brooklyn, NY 11238. Guntur (India) 1970. Special interest, abdominal surgery. Board eligible. Any type practice. Available.

Roshan H. Lalta-Singh, M.D., Roswell Park Memorial Institute, Buffalo, NY 14263. Kolhapur (India) 1968. Special interest, oncology. Board certified. Solo, partnership, multi-specialty group, institutional, public health. Available.

Young Nahm Lee, M.D., 1825 Parkside Drive, Apt. A-2, Park Ridge, IL 60068. Kyungpook (Korea) 1964. Special interest, general medicine. Board eligible. Partnership, multi-specialty group, solo. Available.

Kumar M. Nirmal, M.D., 220 Mount Vernon Place, Apt. 12-C, Newark 07106. K.G. Medical College (Lucknow, India) 1961. Board eligible. Single or multi-specialty group, solo. Available.

Joseph J. Rainone, M.D., 263-45 74th Avenue, Glen Oaks, NY 11004. SUNY-Upstate 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Thomas F. Street, Naval Regional Medical Center, FPO, San Francisco, CA 96652. George Washington 1972. Board certified. Multi-specialty group, partnership, research. Available.

Manuel V. Sarroca, M.D., 300-C Outer Belle Road, Trotwood, OH 45426. University of Philippines 1972. Board eligible. Solo, partnership, group. Available.

Wei H. Lee, M.D., 3001 S. Harrison Street, Denver, CO 80210. Taipei (Taiwan) 1966. Subspecialty, cardiovascular and thoracic surgery. Any type practice. Available.

Parvathareddy Ashok, M.D., 42-55 Colden Street, Apt. 9-E, Flushing, NY 11355. Andhra Medical (India) 1972. Board eligible. Partnership, multi-specialty group, solo. Available.

Michael F. Lane, M.D., 7901 Henry Avenue, Apt. C-411, Philadelphia, PA 19128. SUNY-Downstate 1971. Board eligible. Partnership, single or multi-specialty group. Available.

SURGERY, HEAD/NECK—Joseph B. Jacobs, M.D., 3241 Woodbine Street, Los Angeles, CA 90064. Einstein 1974. Subspecialty, otorhinolaryngology. Board certified (otorhinolaryngology). Partnership, research, multi-specialty group. Available.

SURGERY, ORTHOPEDIC—Rodolfo S. Polintan, M.D., 40-10 165th Street, Flushing, NY 11358. Santo Tomas (Philippines) 1970. Board eligible. Solo, partnership, single-specialty group. Available.

Sheroo Kohli, M.D., 5021 Aurora Avenue, Des Moines, Iowa 50310. G. S. Medical College (India) 1946. Board eligible. Group practice preferred. Available.

James K. Koh, M.D., U.S. Naval Reg. Medical Center, FPO, San Francisco, CA 96652. University of Pennsylvania 1972. Board certified. Single or multi-specialty group, partnership. Available.

Nicholas Cappello, M.D., 663 Young Road, Erie, PA 16509. Creighton 1975. Board eligible. Single or multi-specialty group, partnership, research, public health, emergency room. Available July 1980.

SURGERY, UROLOGICAL—Steven H. Paletsky, M.D., 126-C Remington Avenue, Syracuse, NY 13210. South Carolina 1973. Board eligible. Partnership, solo, single-specialty group. Available.

John Thomas Sommer, M.D., 5325 N. Lakewood Avenue, Chicago, IL 60640. University of Virginia 1972. Partnership, research, single-specialty group. Available July 1980.

Ran Abraham, M.D., 420 East 80th Street, Apt. 8-1, New York, NY 10021. Lausanne 1974. Board eligible. Partnership, single-specialty group, solo. Available.

David J. Caro, M.D., 300 East 34th Street, New York, NY 10016. Cornell 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Vincent J. Lanteri, M.D., 689 Passaic Avenue, Clifton 07012. Guadalajara 1974. Partnership, single-specialty group, solo. Available July 1980.

UROLOGY—H. Barry Opell, M.D., 1275 East 51st Street, Brooklyn, NY 11234. Lausanne (Switzerland) 1971. Board certified. Solo, partnership, group. Available.

Stuart Bergman, M.D., 306 Eastbrook Drive, Charlottesville, VA 22901. Cornell 1973. Board eligible. Group or partnership. Available July 1980.

LETTERS TO THE JOURNAL

Action of the House

May 30, 1979

Dear Dr. Krosnick:

I attended the recent meeting of the Medical Society of New Jersey as a delegate from Morris County. What I am about to comment on represents my own opinion and in no way reflects on the feelings of the County Society.

I was shocked at the House actually opposing 1) catastrophic insurance 2) aid to the elderly, sick, and poor. As a primary care physician, on the firing line in my daily practice, I feel that the action of the House represents poor judgment.

I hope the issue comes to the floor again next year and that men and women of good will representing the humanitarianism of our profession will prevail.

(signed) William Pomerantz, M.D.

Are No Ethics Sacred?

June 11, 1979

Dear Dr. Krosnick:

Thank you so much for your timely editorial "Are No Ethics Sacred?" in the June, 1979 issue of *The Journal* of the Medical Society of New Jersey. I think that the situation that you described related to a small group of physicians who refused to acknowledge the basic concepts of courtesy that physicians traditionally have extended to other members of the profession and relatives of physicians as you outlined. I suspect this small group is not representative of medicine as a whole; it certainly is not in my community. However, I do feel that it does reflect a continuing degeneration of medical ethics and ethics of our society as a whole. Your pointed reference to those of us in our middle and older years

having been reared on ethical canons which now seem to be abandoned is well made. I fear that the younger generation of physicians has not been imbued with the same responsibility to the profession and to "looking after its own" which we were exposed to during our training period.

Again, thank you, Dr. Krosnick, for your editorial.

(signed) Eugene J. Haag, M.D.

June 14, 1979

Dear Doctor Krosnick:

I was deeply moved by your editorial, "Are No Ethics Sacred?" in the current issue of *JMSNJ* (76:412, June 1979).

The expiration of my father a few weeks ago ended several years of such experiences as you speak of, and it was particularly gratifying to find that I am not the "last of the crazies" who expounds on the deplorable state of intraprofessional relations and the degree to which they are responsible for or have added to the poor relationship between physicians and their patients.

Not only have I found almost all of the physicians, radiologists, surgeons, etc., that took part in the futile attempts to keep my Dad alive unwilling to accept as payment-in-full his Medicare PLUS Blue Shield payments, but in a few instances where one or the other insurance carrier has been slow in paying, have sent dunning letters to me threatening to turn me over to a collection agency for the small pittance remaining on the bill (though I was not even legally responsible for payment)! One local physician, covering for the regular cardiologist, unable to leave his house because of snow (though I found it not at all difficult, and I live only 4 blocks from

him!) when an emergency admission to the hospital was required, received *from me* the necessary medical orders and telephoned them to the hospital floor nurse. This was the sum total of his services; he never saw my father. But he still demands the last few dollars due after Medicare and Blue Shield paid their shares.

Are we, indeed, what the lay press and consumer advocates call us: money-hungry businessmen in the *commerce* of health care delivery? I always considered a request to care for an immediate family member of a colleague to be the highest compliment that could be paid to me. It meant that my peer so thoroughly respected my competence that he entrusted his loved one to my care. I could not imagine charging my colleague for such services, much less threatening him with legal action! What shall we look for next: physicians suing each other for malpractice when one's quite subjective evaluation of the care given to a family member concludes that the attending physician did not measure up to our standards (which, of course, can so easily be translated as "he didn't cure Dad/Mom/spouse or save him from death as a result of an incurably fatal illness")? Are we trying to answer the public criticism of the medical profession by an attitude of "You ain't seen nuttin' yet!" (paraphrasing Al Jolson's well-known remark), by acting in a manner that even our worst critics never dreamt we could stoop to?

I sincerely hope that your editorial is read carefully by all of our fellow *MSNJ* members, and that they take it to heart and reflect on its message. I shall make some attempts to disseminate it in a few well-needed directions, not because of the few dollars I have spent for my father's care in the last two years of his life, but because of the chagrin and professional shame with which I viewed my colleagues' attitudes, and the shock I share with you.

Thank you for using your position to

say what was in desperate need of being said. Some, like myself, have a limited audience for our outcry, and since it comes in the midst of a situation which touches our own pockets, are accused of having selfish and ulterior motives for espousing the philosophy. You, on the other hand, have a significant forum from which to fire, and those of us who still believe in *ethics* are grateful.

(signed) Donald J. Flaster, M.D., LL.B.

June 26, 1979

Dear Dr. Krosnick:

The editorial entitled "Are No Ethics Sacred?" was read by me with interest. The problem of accepting assignment on an individual who has expired is not a simple one. Those of us who have been involved in these situations wonder whether the unethical practices are with the Government, the insurance company, or the physician.

Are you aware of the fact that Medicare will not pay anything to the estate if the physician will not accept assignment? There are many of us who just are

not interested in accepting assignment on Medicare, but who are willing to cancel the 20% additional payment and cooperate in many ways, and are concerned about the welfare of patients. We certainly would be glad to treat the patient's estate the same way; in other words, refuse to accept assignment but then permit the estate to pay us whatever Medicare allows, not even requesting the additional 20%.

So you see, the problem is with the Medicare plan in many cases and not with the physicians. If I were to choose to charge the patient whatever Medicare allowed but insisted on a direct payment from the patient's estate, Medicare will pay nothing. This is hardly ethical. If I accept assignment on Medicare, I am at their mercy for them to decide what they think the services are worth, and in my experience under these circumstances they frequently pick a fee far below what they would settle on when the patient was still alive and kicking and able to go to bat for the physician. In no way would I defend the physicians who insisted upon full and direct payment of their fees, except in the case where the individual so treated was perfectly capable of paying those fees, but I cer-

tainly would defend the physician who would insist upon direct payment and accept whatever Medicare would allow. Unfortunately, it doesn't work that way and Medicare allows nothing once the patient has died. So you see, that the ethical problem here is on both sides and I was wondering whether or not you were aware of these technicalities.

(signed) Christopher T. Reilly, M.D.

July 3, 1979

Dear Doctor Krosnick:

I enjoyed your editorial in the June 1979 *Journal* (76:412), "Are No Ethics Sacred?"

Here, as quoted from a recent communication from an anesthesiologist at Jefferson, is an example of good ethics:

"We are pleased to be able to participate in the surgical care of physicians and their families. The anesthesiologists at Thomas Jefferson University regard it as a privilege and there is no charge to you for the anesthesia care."

(signed) John S. Madara, M.D.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

MEDICINE (includes Family, Internal, and General Medicine and Dermatology)

Sept.

- 5 Arrhythmia Management**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*St. Mary's Hospital and AMNJ*)

- 5 Medico-Legal Seminar**
9 a.m.-4 p.m.—Inter-Agency Commission, Lawrenceville
(*Inter-Agency Commission on Emergency Medical Care and AMNJ*)
- 6 Psychoendocrine Findings**
- 13 Drug Incompatibilities**
- 20 Advances in Neurology**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 12 Depression Seen in the Family**
Practitioner's Office
- 19 Hyperalimentation**
- 26 Rheumatology**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 13 Asthma Update**
8-9 p.m.—Mount Holly Center, 62 Richmond Ave., Mount Holly

(*Burlington County Medical Society and AMNJ*)

- 15- Multiple Sclerosis Symposium**
- 16 9 a.m.-5:30 p.m.—VA Medical Center**
East Orange
(*VA Medical Center and AMNJ*)
- 17 Hypokalemic Alkalosis**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 19 Medical Grand Rounds (Pulmonary Disease Section)**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- Advances in Infectious Diseases**
- 24 8 a.m.-4:30 p.m.**
- 25 9 a.m.-4:45 p.m.**
- 26 9 a.m.-12 noon—Resorts International,**
Atlantic City

CME
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Page 632

**SEVENTH OFFICIAL POSTGRADUATE COURSE IN
 ACUPUNCTURE & PAIN CONTROL
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 CREDITS—25 HOURS
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MEDICOLEGAL SEMINAR III

September 12, 1979

- 8:30 a.m. —Registration
 - 9:00 a.m. —Welcome—Jack R. Karel, M.D., Chairman, ICEMC
 - 9:10 a.m. —Bernard H. Genest, Director, Claims Administration, Inter-Insurance Exchange of New Jersey
 - a) Loss Prevention—How To Avoid Claims
 - b) Loss Control—What Happens After a Claim is Reported
 - 11:30 a.m. —Question and Answer Period
 - 12:00 a.m. —Lunch
 - 1:00 p.m. —Bernard L. Eichler, J.D., Counsellor at Law, Lecturer at N.J. College of Medicine and Dentistry
 Impact of Governmental Regulation and Planning on Responsibilities and Obligations on every level of Emergency Medical Care. This will include discussion concerning existing legislation on individual liability and how it adapts to present and future medical care plans.
 - 2:30 p.m. —James E. George, M.D., J.D., MSNJ Director of Liability Control, Member, Board of Directors of ACEP
 - 3:30 p.m. —Question and Answer Period
 - 4:00 p.m. —Adjournment
- Attendance will be by registration only.
 The registration fee will be as follows:
 \$35.00—Physicians
 30.00—Nurses
 15.00—First Aid Rescue Personnel
 35.00—All Others

*Luncheon will be served without charge.
 Category I Continuation Medical Credit approved.*

Send registration and fee to ICEMC, The Medical Society of New Jersey, 2 Princess Road, Lawrenceville, N.J. 08648. Site of the Seminar will be at the address noted above.

(CMDNJ-NJ Medical School, St. Michael's Medical Center, Newark and AMNJ)

- 26 Diagnosis and Treatment of Infectious Disease**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

Oct.

- 6 EKG Course for Primary Care Physicians**
8:30 a.m.-5:30 p.m.—Sheraton Heights Hotel, Hasbrouck Heights
(South Bergen Hospital and AMNJ)
- Cancer Update 1979**
- 6** 9 a.m.-5 p.m.
- 7** 9 a.m.-12 noon—Meadowlands Hilton, Secaucus
(Bergen County Unit, American Cancer Society, Bergen County Medical Society and AMNJ)
- 9 Hepatitis Update**
8:30-9:30 p.m.—Riverside General Hospital, Secaucus
(Riverside General Hospital and AMNJ)
- 10 NJ Society of Critical Care Medicine**
8:45 a.m.-4 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)
- 10 Preservation of the Ischemic Myocardium**
- 17 Clinical Disorders of Respiratory Control**
- 24 Geriatric Medicine**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)
- 11 Mitral Valve Prolapse**
8-9:30 p.m.—Deborah Heart and Lung Center, Browns Mills
(Burlington County Medical Society and AMNJ)
- 17 Update on TPN and Neoplastic Disease**
8:45 a.m.-5 p.m.—John F. Kennedy Medical Center, Edison
(John F. Kennedy Medical Center and AMNJ)
- 17 Hypersensitivity Pneumonitis**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)
- Internal Medicine—Cardiology**
- 20** 8 a.m.-5:30 p.m.
- 21** 8:30 a.m.-4:20 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 22 Inflammatory Bowel Disease**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)
- 25 Brain Biochemistry and Behavior**
1:30-5:30 p.m.—Drew University, Madison
(Drew University, CIBA-Geigy Pharmaceutical Division and AMNJ)

NEUROLOGY/PSYCHIATRY

Sept.

- 5 Suicidal and Homicidal Patients**

- 19 Dx and Rx Agoraphobia**
- 26 Obsessive Compulsives and Phobias—Flooding**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)
- 11 Stress-Related Disorders**
8:30-9:30 p.m.—Riverside General Hospital, Secaucus
(Riverside General Hospital and AMNJ)
- 12 Grand Rounds in Psychiatry and Mental Health Science**
1:30-3:00 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 20 Psychoanalytic Theory of the Instinctual Drive**
8:30-10:30 p.m.—Hackensack Hospital (NJ Psychoanalytic Society and AMNJ)
- 27 Laboratory Use in Clinical Psychiatry**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)

Oct.

- 3 Treatment of Syncopal Episodes**
- 31 The Borderland between Neurology and Psychiatry**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)
- 3 Death and Dying and the Family**
- 17 Family Therapy (Videotape)**
- 24 Family Therapy**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)
- 3 Symposia—The Child at Risk**
- 10** 9 a.m.-5 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and Devereux Foundation)
- 4 Tension Type Headaches**
- 11 Computers in Psychiatry—Use and Abuse**
- 18 When, How, and Why To Use Antidepressants**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 18 Mythology Content of Scientific Cosmetology**
8:30-10:30 p.m.—Hackensack Hospital (NJ Psychoanalytic Society and AMNJ)
- 31 The Borderland between Neurology and Psychiatry**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

OBSTETRICS/GYNECOLOGY

Sept.

- 5 Combined Grand Rounds in Ob/Gyn**
- 12** 3-5 p.m.—Rotates between CMDNJ-College Hospital, Newark Beth Israel and St. Michael's Medical Center, Newark, St. Joseph Hospital and Medical Center, Paterson, and Jersey

City Medical Center
(CMDNJ and AMNJ)

- 6 Grand Rounds in Ob/Gyn**
- 13** 4-5 p.m.—CMDNJ-College Hospital, Newark
- 20** Newark
(CMDNJ and AMNJ)
- 13- Fifth Annual Ignatz Semmelweis**
- 16 Obstetrical Seminar**
Cherry Hill Inn, Cherry Hill
(CMDNJ and AMNJ)

Oct.

- 3 Lectures in Obstetrics and Gynecology**
8-10 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 3 Combined Grand Rounds in Ob/Gyn**
- 10** 3-5 p.m.—Rotates between CMDNJ-College Hospital, Newark Beth Israel and St. Michael's Medical Centers, Newark, St. Joseph's Hospital and Medical Center, Paterson, and Jersey City Medical Center
(CMDNJ and AMNJ)
- 4 Grand Rounds in Obstetrics and**
- 11 Gynecology**
- 18** 4-5 p.m.—College Hospital, Newark
- 25** (CMDNJ and AMNJ)

GENERAL SURGERY

Sept.

- 13 Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

Oct.

- 2 Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)
- 11 Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)
- 13 Total Parenteral Nutrition**
8:30 a.m.-1:30 p.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

SURGICAL SPECIALISTS (includes ENT, neurosurgery, ophthalmology, orthopedic, plastic, and vascular surgery)

Sept.

- 25 Retropubic Prostatectomy**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

Oct.

- 4 Organization of Developmental Information**
- 11 Oogenesis**
- 18 Spermatogenesis**
- 25 Cytoplasmic Information**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

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Dr. Lawrence M. Green

At the untimely age of 38, Lawrence M. Green, M.D., a member of our Passaic County component, died suddenly on June 1 at Chilton Memorial Hospital, Pompton Plains. A native of New York City, Dr. Green earned his medical degree at Dalhousie University in Nova Scotia in 1967 and took a residency in obstetrics and gynecology at Maimonides Medical Center in Brooklyn. Following a tour of duty with the United States Navy's department of medicine, he established a private practice in his specialty in Wayne. He was a diplomate of the American Board of Obstetrics and Gynecology and had been on the staff at Chilton Memorial Hospital.

Dr. Harry Halprin

Harry Halprin, M.D., of Montclair, a senior member of the Essex County Medical Society, died in May. Born at the turn of the century, Dr. Halprin earned his medical degree from New York University's College of Medicine in 1923, and pursued a career in internal medicine, becoming board certified in that specialty. He took graduate training in cardiology at Mount Sinai and Graduate Hospitals in New York. Dr. Halprin was a Fellow of the American College of Cardiology and of the American College of Physicians. He had been on the staff at Community and Mountainside Hospitals in Montclair. In 1973 Dr. Halprin received the Medical Society of New Jersey's Golden Merit Award indicating 50 years of practice. He had been active in community affairs and

served for many years as president of the board of health in Caldwell.

Dr. Lester Kiefer

The director of the department of pathology at Perth Amboy General Hospital, Lester Kiefer, M.D., a member of our Middlesex County component, died on June 18. A native of Maryland, born in 1922, Dr. Kiefer completed his medical education at the University of Pennsylvania School of Medicine in 1953, and following internship took graduate work in pathology at the University of Maryland Hospital. He was board certified in his specialty and a Fellow of the American College of Pathologists and of the American Society of Clinical Pathologists, and a member of the American College of Physicians. Before coming to New Jersey in 1971 to accept his present position, Dr. Kiefer had been laboratory director of Memorial Hospital in Cumberland, Maryland and an assistant professor of pathology at the University of Maryland School of Medicine.

Dr. Vincent Pidoto

A member of our Middlesex County component, Vincent Pidoto, M.D., died on June 10. A native of New York City, born in 1916, Dr. Pidoto earned his degree in medicine from the University of Bologna (Italy) in 1943 and pursued a career in internal medicine with particular emphasis on chest diseases. He had been assistant medical director at Roosevelt Hospital in Metuchen and on the attending staff in internal medicine at John F. Kennedy Memorial Hospital in

Edison. Dr. Pidoto was a Fellow of the American College of Chest Physicians.

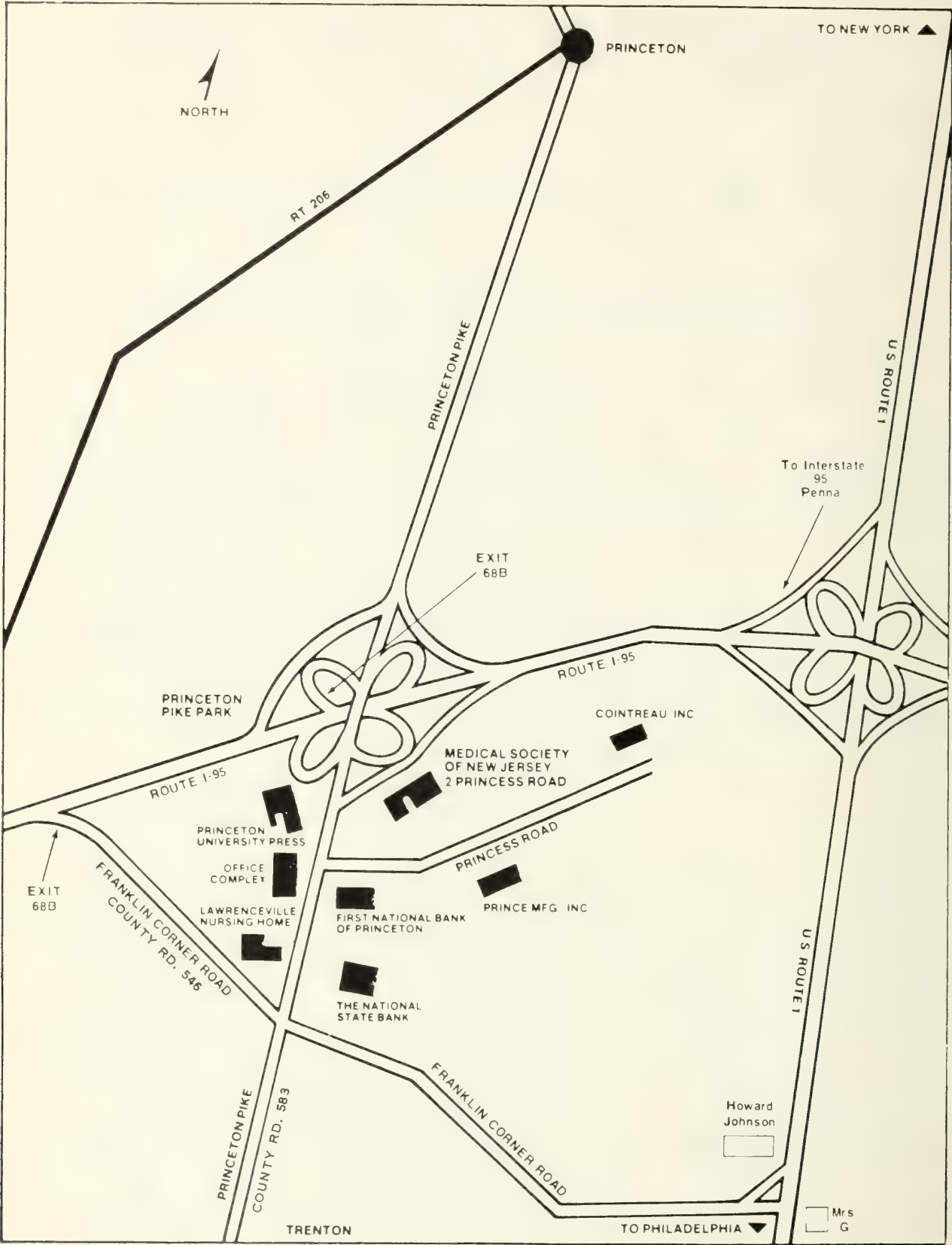
Dr. Sydney H. Shapiro

On May 8, Sydney H. Shapiro, M.D., a member of the Essex County Medical Society, died at his home. Born in 1912, Dr. Shapiro earned his medical degree from the University of Maryland College of Medicine, class of 1935. He was a family practitioner and had been affiliated with Irvington General and Alexian Brothers Hospitals in Elizabeth and Beth Israel Medical Center in Newark. Dr. Shapiro also held appointment on the staff at the Seaview Hospital on Staten Island.

Dr. Earl L. Warren

A senior member of our Passaic County component, Earl L. Warren, M.D., died on May 30 at Valley Hospital in Ridgewood. A native of Georgia where he earned his medical degree from the University of Georgia in 1925, Dr. Warren took graduate training in chest diseases there and at the Valley Hospital and returned to his native community to practice. Subsequently he pursued a career in radiology and returned to New Jersey where he ultimately became director of that department at Greater Paterson General Hospital. He also served as a member of the medical board of the hospital. In 1975 Dr. Warren was a recipient of MSNJ's Golden Merit Award indicating 50 years of practice. He had been active in community affairs and had been president of the Greater Paterson Chamber of Commerce. Dr. Warren was 77 years old at the time of his death.

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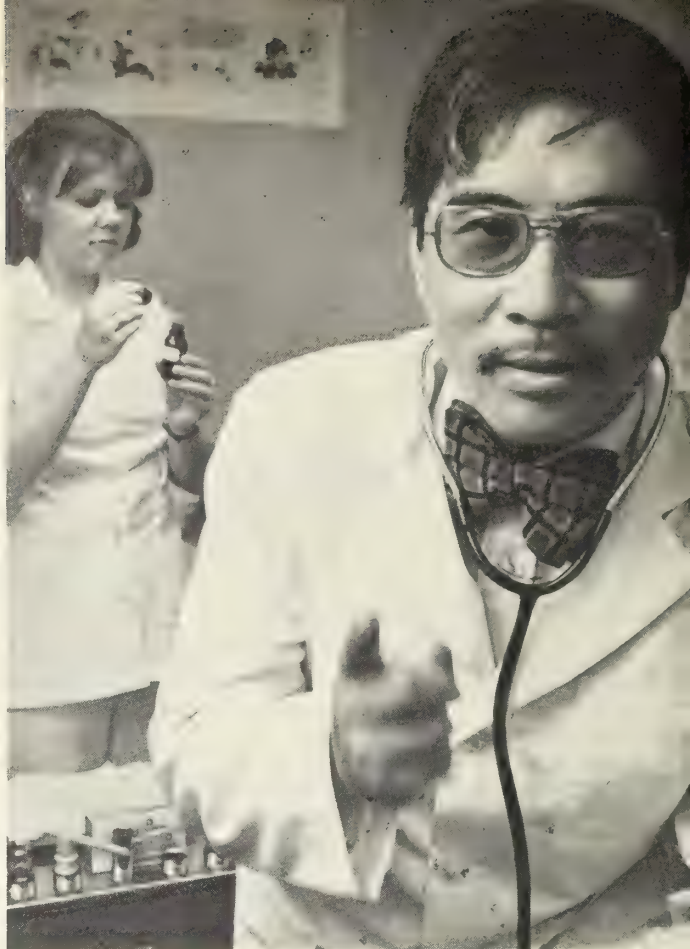
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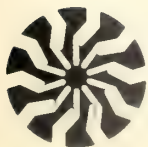
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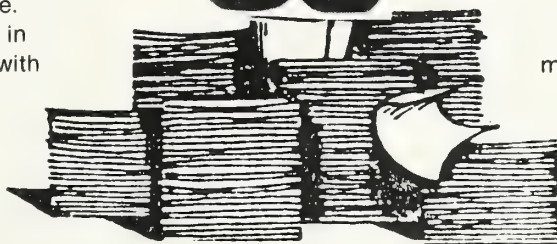
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AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION

Nausea and vomiting of pregnancy.

PRECAUTIONS

Because of potential drowsiness, Bendectin should be prescribed with caution for patients who must drive automobiles or operate machinery. Studies in rats and rabbits have revealed no suggestion of drug-induced fetal abnormalities at doses of Bendectin up to 90 times the maximum human dose. In addition, several epidemiologic studies in women who received Bendectin during pregnancy have shown that the incidence of birth defects in their offspring is no higher than in women not taking the drug during pregnancy. Nevertheless, like all drugs considered for use during pregnancy, particularly during the first trimester, Bendectin should be used only when clearly needed.

ADVERSE REACTIONS

The adverse reactions that may occur are those of the individual ingredients. Doxylamine succinate may cause drowsiness, vertigo, nervousness, epigastric pain, headache, palpitation, diarrhea, disorientation, or irritability.

Pyridoxine hydrochloride is a vitamin that is generally recognized as having no adverse effects.

DOSAGE AND ADMINISTRATION

2 Bendectin tablets at bedtime. In severe cases or when nausea occurs during the day: 1 additional Bendectin tablet in the morning and another in midafternoon.

Product Information as of January, 1978

References:

1. Meyer, C.: American Folk Medicine. Scarborough, New York, Plum Books — New American Library, 1975, p. 208.
2. Data on file, MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

1830: A decoction of columbo root and peppermint 3 or 4 times a day should be taken for the sickness to which pregnant females are commonly subject.¹

TODAY: Clinical studies show statistically proven efficacy for morning sickness of pregnancy with delayed-release Bendectin tablets.²



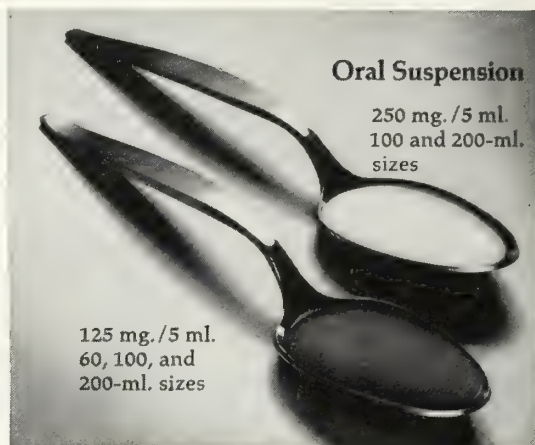
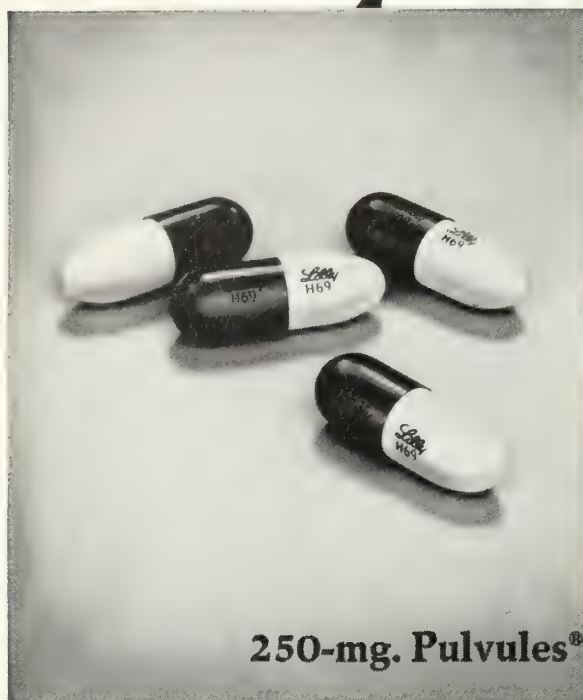
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The Public Takeover of Medicine*

Ben Johnson, in 1770, made the observation "Nothing so concentrates a man's mind as the knowledge that on the morrow he is to be hanged." Perhaps in this statement there is a message for the medical profession as we face the immediate future.

A MEDICAL-SOCIAL PARADOX

This is a time of peculiar paradox for the medical profession. It is little wonder that the average physician is incredulous when, after having been taught to do all things possible for all those with whom he comes in contact and, as a result of this, having striven to produce what is now recognized throughout the world as the finest health care system known, he now faces increasingly severe criticism from all sides. He knows how the President of the United States feels after hearing comments such as "the greatest impediment to progress in health care is the American Medical Association" and "if the Congress really wants to do something about inflation they will come down hard on health care costs." The physician hears [former] DHEW Secretary Califano emphasizing fraud and abuse within the system. He suggests that it is rampant, yet is unable to produce any meaningful figures. But worse yet, society itself seems to join in this chant. Ralph Nader and his group continue to ferment unrest, and Dr. Sidney Wolfe is convinced that no physician knows how to use drugs. The litany can go on including the Gray Panthers, allied health personnel, state and local governments, all of whom perceive defects within the health care system purposely created and worthy of elimination.

Make no mistake about it, there is now a concerted drive for the public takeover of medicine, not to make it better, but to make it more uniform and controllable. To some degree, it must be admitted that this is not entirely without justification. The fact is that health is the second largest and most heavily subsidized industry in this country. Health care utilizes ten percent of the federal budget and nine percent of the gross national product. Little wonder that the public sector has increasing interest in how these resources are spent; they will continue to attempt to gain control over them.

Expectations are changing, and now it is not that the providers of medical care will try to do society ill, it is that they will try to do too much good! Ivan Illich, in his latest social blast called "Medical Nemesis" (which should be standard reading for all physicians), reaches the startling conclusion that the medical establishment has become a major threat to health. He sees that society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be

done to such people. This, he maintains, has resulted in rituals: for example, the yearly but probably unnecessary physical examination, the long-term maintenance of the hopelessly ill, the medicating of any and all conditions, and the production of medicine as a commodity which, if only extended far enough, should assure good health.

MEDICALIZATION OF SOCIETY

It is this medicalization of society which ends up spending 30 percent of the budget on 10 percent of the people, increases the use of tranquilizers ten times that of alcohol, and in the end deprives the citizen of his ability to understand or determine his own medical future, not infrequently forcing courts to make medical decisions. Illich concludes by saying, "The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population. This ability to cope can be enhanced, but never replaced by medical intervention. The society which can reduce professional intervention to the minimum will provide the best conditions for health." Think about it!

Without much doubt we have been too successful in the development of medical technology. Should we, for example, marvel over the transplantation of a heart, when children in the inner cities are dying of diseases for which they could be immunized? It would be reassuring to assume that technology is impersonal in development and, therefore, justified at all levels. But, like it or not, every new program reflects and influences values, ideas, theories, and beliefs, and as medical sciences have advanced, the related social and ethical issues have been multiplied beyond expectation.

The conclusion is inescapable that the medical profession no longer can function independently from society, as much as we might like to think a science should. More than a century ago Oliver Wendell Holmes said, "The truth is that medicine, professedly founded on observation, is as sensitive to outside influences—political, religious, philosophical, imaginative—as is the barometer to changes in atmospheric density."

George Bernard Shaw went a bit further and stated flatly, "Every profession is a conspiracy against the laity."

It is the appearance of benefit from closely held expertise that angers the public and increases the demand for supervision and regulation. What every professional should bear in mind is the distinction between a profession and a function. The function may be external, but the profession is

*Presented before the Section on Orthopaedic Surgery and Family Practice, 213th Annual Meeting, the Medical Society of New Jersey, May 14, 1979 by James S. Todd, M.D., Chairman of the Board of Trustees of MSNJ.

temporal and can be destroyed or destroy itself very rapidly. Put most simply, the town crier is gone, but the broadcaster on the electronic media fulfills the same function, but in a different form.

All professions, even though seemingly ancient and continuous, have changed. It seems to me that medicine is slower than most. Everyone should begin to realize that the profession does not exist for itself, but for a purpose, therefore it must practice under the constraints set by those who commission its work. The modern profession has enjoyed its monopoly for so long that it tends to forget that it is a privilege given in exchange for human benefit. No longer is the all-pervading paternalism of medicine acceptable in our current society. No longer is the medical profession perceived as the sole guardian of public health. Physicians must not fall prey to the belief that all benefit comes from traditional medical practices. The public now perceives medicine as not being truly responsive to its needs, and when expectations are thwarted conflict inevitably results.

Current opinion polls suggest that Americans are ready for a change in health care and, whether you agree with that or not, you have to agree with Harvey Cushing when he wrote to Franklin Roosevelt, "No legislation can be effective without the goodwill of the medical profession which has the organization to put it to work."

AWESOME RESPONSIBILITIES

This simple fact carries awesome responsibilities. No longer can we afford the luxury of opposition without viable alterations to clearly existing problems. No longer can we make decisions based on desire for expediency. We now must assemble the hard facts, interpret them rationally, and move toward the goals dictated by those facts. We need not compromise with principle, but we do need to face reality squarely and unafraid.

To dwell on reality for a bit, it is all too tempting to explain away our problems and say that under the circumstances we are doing a good job. In many respects we are. Reality, however, tells us there is a whole array of alternative professionals—chiropractors, podiatrists, optometrists, psychologists—whom the public has chosen to license and to utilize. Ignoring or trying to reject them is no longer feasible or possible. We must find ways to accommodate them in the health care system where we may find them helpful or the public more clearly may see their failings. Reality tells us there is incompetence within the profession; although not in large quantity, there is enough to give our critics grist for their mills. We must deal sternly with this. Reality also states there is negligent and inappropriate medical care being given

—not a great deal, but enough to produce and sustain the malpractice crisis leading to the development of 19 medical society-sponsored companies trying not only to deal with economics, but with the problem of negligence itself. More importantly, reality tells us there are people out there who are not getting the care they need because of inaccessibility or inability to afford it and that health care costs continue to rise more rapidly than even we can justify.

These are the pressing issues which the profession must address with all the vigor it possesses. These are the very issues upon which the future of medicine will be determined.

Of equal concern, however, should be the fact that this huge press for change by the government and the public never has been, and is not now being guided by anyone who has any perception of the consequences of his decisions and actions. Yet, let us not be too smug, because we also must recognize that there has been no real leadership of the health care system either. Only an array of special interests exists; each is determined to promote its own cause at the expense of others. And if you doubt this, watch the battle between the plastic surgeons and the otolaryngologists regarding rhinoplasties!

WHAT IS THE FUTURE?

We are no longer a free profession in the full sense of the word, but that reality should in no way diminish our stature or our ability to contribute meaningfully to the improvement of society. On our present course, inexorably there will be a public takeover of medicine. While many of these events are perhaps justifiable consequences of our modern societal attitudes, I would suggest, more often than not they are the results of vacuums created or tolerated by the profession itself. Somewhere there is a balance between societal demands and professional capabilities.

The emerging great problem of our times is not how to control change, but rather how to direct and control it so that it does not overwhelm us. The ultimate tragedy of American medicine may well be that while quick to accept scientific change it could not adapt to the social consequences of those changes.

The profession probably is facing its last opportunity to provide the kind of leadership upon which our credibility and very survival will depend. Unless we seize that leadership role, the word physician well may be replaced by the word provider.

Periodically, we all can expect to operate with great doubt but, if we can conquer that doubt through realistic evaluations, sound decision making, and unified action, we can be worthy of the moment and of the future.

James S. Todd, M.D.

Freedom (?) at Any Cost

A misguided, oftentimes emotional distortion of constitutional freedoms seems to be an attractive vote-getting technique for incumbent politicians at all levels, including state legislatures. Short shrift or no shrift is given to the costs or potential costs of their actions and always the taxpayer gets hurt.

The latest is the New York "Truth-in-Testing" law which takes effect in our neighboring state in January, 1980. Henceforth, graded Scholastic Aptitude Tests (SATs), dental, medical, law, and other standard aptitude tests will be made available to the applicants and the government after the tests have been given in that state.

Governor Hugh Carey believes, "It must be a candidate's right to have access to his results." One must wonder why. The student who does well won't care. The student who does poorly is not likely to gain anything by review of the test questions and answers after the fact. Aptitude test information is not applicable to the knowledge store into which one dips in future problem solving in life. The test measures what it measures and nothing more!

When the Educational Testing Service of Princeton (ETS), which prepares and administers the so-called college board tests, suggested that the costs of preparation of new examination questions for each testing session would add considerably to the cost, Governor Carey retorted, "I am not persuaded" that is so. It takes very little knowledge to

understand that writing good questions for many different tests is a time-consuming, difficult, and expensive procedure.

The myopic view of the New York State Legislature and Governor Carey is even more annoying when one realizes that a single state law will raise costs for the citizens in every other state in the Union, without their ability to participate in such a decision.

There is no lesson to be learned from this behavior, because we already know it. Politicians will pass laws which they and the "consumer advocates" conceive will help their image no matter what the cost and no matter who pays the bill. The intrusion of government, however, in confidential data from ETS and the testing industry in general is alarming.

A.K.

Therapeutics Over a Quarter of a Millenium

If a modern physician were asked some principles of health and lifestyle which would prevent or cure many—if not most—of man's ailments, he might include the following:

1. Eat a simple and easy-to-digest diet which includes salt and condiments in limited amounts.
2. Avoid or sharply limit the intake of strong alcoholic beverages.
3. Regular exercise is necessary and walking is the best exercise.
4. Exercise is best on an empty stomach and should never cause exhaustion.
5. Coffee and tea consumption should be limited by tense individuals.
6. Have faith in God.
7. Get a full night's sleep daily.
8. Emotional tension should be prevented or controlled or your medication won't work.
9. Take your medications exactly as prescribed.

This remarkably apt list was drawn from experience, ancient teaching, and intuition, rather than scientific investigation. It is included in the preface of a book, originally written by Dr. John Wesley in 1747 and reprinted in 16 editions in Trenton, England.*

Today we would add many advices, such as restriction of cholesterol and saturated fat, abstinence from tobacco, avoidance of obesity, and so on, but 240 years from now our program may not hold up as well as Wesley's. A casual review of his herbal remedies may leave one cold, but this revolutionary-period physician was both optimistic and pragmatic. Although he had an "easy and natural method of curing most diseases," Wesley listed several alternatives with the admonition that the remedies for each disease be used as listed; but, after a time, if "no effect, use the second, the third, and so on."

Although Wesley had cures for apoplexy, hemoptysis, hematemesis, cancer, the "bite of a mad dog," and so on, his reference to diabetes was most interesting to this editor. He

defined diabetes as "a frequent and large discharge of pale and sweetish urine, attended with a constant thirst, and a wasting of the whole body." The treatments for diabetes were as follows:

"297. Drink wine boiled with ginger, as much and as often as your strength will bear. Let your drink be milk and water. All milk meats are good.

"298. Or, drink three or four times a day a quarter of a pint of alum posset, putting three drams of alum to four pints of milk. It seldom fails to cure in eight to ten days.

"299. Or, infuse half an ounce of cantharides in a pound of elixir of vitriol. Give from 15 to 30, or even 40 drops in Bristol water twice or thrice a day."

The pharmaceutical industry is well aware of the potential benefits of the instinctive remedies of days past, but it is hard to see what alum posset (aluminum and potassium sulfate) and milk would do for the insulin-dependent diabetic. Internally, it would serve as an emetic and perhaps as an astringent and hemostatic. Cantharides, the blistering or Spanish fly, in moderate dose internally, had a diuretic and stimulant effect on the urinary and reproductive organs. Elixir of vitriol is aromatic sulfuric acid. Today, insulin is better! One must wonder whether the "cure in eight or ten days" represented a "cure" through termination.

Although a quarter of a millenium is a speck on the history of the world, a review of treatment programs in those days and today is eye-opening. The technical advances of the last two decades have pushed medicine farther and faster into the future than the previous two centuries. Mind-boggling though they may be, the challenges of medicine and surgery of the future will continue to provide excitement to the practitioners of the art and science and benefits to the patients. Despite all the scientific advances of the future, however, physicians may need to throw in a little security blanket, as did Wesley:

"Above all, add to the rest (for it is not labour lost) that old unfashionable medicine, prayer."

A.K.

*Wesley, John: *Primitive Physic or An Easy and Natural Method of Curing Most Diseases*. 16th ed. Trenton, England, 1788.

must What you ~~should~~ know about the newly enacted New Jersey Drug Substitution law

As of April 23, 1979, the state dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until then, writing the brand name of a drug on the prescription was enough to ensure that the same brand-name drug would indeed be dispensed. Now that no longer suffices. Unless the

physician takes the necessary extra steps, for many drugs the pharmacist must substitute a lower-cost brand name of that drug or a lower-cost "equivalent" generic drug contained in the latest list of interchangeable drug products published by the Drug Utilization Review Council.

New prescription form shows two prescribing options

The law states:

- "Every prescription blank shall be imprinted with the words 'substitution permissible' and 'do not substitute' and shall contain space for the physician's or other authorized prescriber's initials next to the chosen option."

NOTE:

- "For prescriptions filled other than by mail, the consumer may, if a substitution is indicated and prior to having his prescription filled, request the pharmacist or his agent to inform him of the price savings that would result from substitution. If the consumer is not satisfied with said price savings he may, upon request, be dispensed the drug product prescribed by the physician. The pharmacist shall make a notation of such request upon the prescription blank."
- "If a nonbrand-name drug product is dispensed, the pharmacist shall include on the label of such drug product dispensed pursuant to a prescription, the established name or the name of the manufacturer, except where the prescriber indicates to the contrary on the prescription."

Rx

substitution permissible _____
do not substitute _____ (initial)

MD

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription form illustrated on the preceding page. This form requires a distinct change from the way he has previously written prescriptions.

There are now *two* spaces for the prescriber's initials. The prescription will be filled generically or with another brand name of that drug unless the physician initials the space stating "do not substitute." When transmitting an oral prescription, the physician must explicitly state that there shall be no substitution. Only by taking these

measures can he ensure that the brand-name drug he prescribes will actually be dispensed.

If the physician elects to permit substitution, he must indicate this by initialing the space marked "substitution permissible." The drug actually dispensed must be of lower cost and must be contained in the latest published list of interchangeable drug products. Substitutions shall not be made unless cost savings are passed on to the consumer.

Please refer to a copy of the law for complete details.

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Lithium Toxicity

WILLIAM F. HAYNES, JR., M.D., Princeton
JAMES L. ELMORE, M.D., Belle Mead*

Adverse reaction of lithium with hydrochlorothiazide results in reversible electrocardiographic abnormalities and physical signs and symptoms of lithium toxicity. Factors ushering in the toxic state and its management are discussed. There is significant risk of toxicity in individuals being treated concomitantly for hypertension with thiazide or thiazide-like diuretics and lithium for manic-depressive reaction.

Lithium administration is effective for the prophylaxis and treatment of acute and recurrent manic-depressive disorders. Criteria for diagnosis of manic episodes include elevated mood, increased activity, talkativeness, and increased self-esteem, grandiosity, flight of ideas, irritability, distractibility, decreased sleep, and poor judgment. The disturbance should be sustained for one week and include no symptoms suggesting schizophrenia or organic mental disorder¹. Lithium has been found effective in the treatment of manic-depressive psychosis in many studies² since first used by Cade for this disorder in 1949³.

Since lithium is excreted almost exclusively through the kidneys, the serum level of the drug is determined by the particular maintenance dose, as well as by the renal elimination of the compound. Thiazide (e.g., Hydrodiuril®) and thiazide-like diuretics (chlorthalidone) are among a class of drugs that alter renal lithium clearance and therefore are potentially dangerous to patients undergoing lithium treatment. Recently, Jefferson and Kalin⁴ found that the "loop diuretic" (furosemide) blocked reabsorption of lithium in the ascending limb of Henle's loop where a substantial amount of lithium normally is reabsorbed. They demonstrated in normal volunteers that the combined use of a loop diuretic and lithium may not require modification of the lithium dosage. However, loop diuretics (furosemide and ethacrynic acid) are so potent and have such a short duration of action that a smooth, sustained reduction in blood pressure is not

possible without a frequent dosage schedule. In addition, the brisk diuresis with these drugs makes many patients uncomfortable especially at night. Hence, these drugs are employed very infrequently, if at all, for long-term management of essential hypertension. Laboratory experiments have shown that the daily administration of hydrochlorothiazide (Hydrodiuril®) to rats during a two to four-week period led to a reduction of lithium clearance by 30 to 35 percent⁵. Peterson and coworkers found that thiazide administration to eight men and fourteen women resulted in a 24 percent reduction in lithium clearance⁶.

The National Committee on Hypertension recognized diuretics as the cornerstone for the treatment of this condition. There may be 35 million or more hypertensive patients under treatment with diuretics at this time. In 1970, lithium carbonate was approved by the Food and Drug Administration (FDA) for the treatment of acute mania and in 1974 it was approved for prevention of recurrent manic attacks.

The incidence of manic-depressive reactions is said to be three to four per thousand. In the United States, then, there may be 600,000 to 800,000 patients with this disorder. In 1970, there were 69,339 admissions of manic-depressive patients to all United States inpatient and outpatient psy-

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Many thousands of patients are being treated with lithium at this time, and a number of these are likely to be under treatment for concomitant hypertension with diuretics.

chiatric services⁷. Many thousands of patients are being treated with lithium at this time, and a number of these are likely to be under treatment for concomitant hypertension with diuretics.

The physician should be aware of the possible deleterious drug interactions between thiazide diuretics and lithium. Their combination may lead to lithium toxicity, a serious and potentially fatal disorder. Lithium toxicity may produce a complex clinical picture involving several organ systems. Neuromuscular involvement may include tremor, fasciculation, twitching, clonic movements, ataxia, and hyperactive deep-tendon reflexes. At the central nervous system level, symptoms may include blackouts, seizures, slurred speech, dizziness, incontinence, and progressive decline in the level of consciousness, proceeding through stages from lethargy to coma. Cardiac arrhythmias, hypotension, and peripheral circulatory collapse likewise may occur.

Other toxic effects involve the gastrointestinal system, consisting of anorexia, nausea, vomiting, and diarrhea. The patient may experience oliguria, polyuria, albuminuria, or glycosuria. Blurred vision and dry mouth may occur, as well as numbness of the skin, dehydration, and weight loss. Thirst, leg ulcers, headache, itching, swelling, weight gain, and metallic taste also have been described.

Laboratory changes unrelated to dose include lowered protein bound iodine (PBI) and increased I-131 uptake. Electroencephalographic abnormalities and electrocardiographic T-wave changes have been described.

CASE REPORT

A 58-year-old manic-depressive, hypertensive male was admitted to the Medical Center at Princeton with complaints of decreased appetite and taste, 20-pound weight loss, progressive apathy, and unsteady gait over the preceding four weeks. Some twitching of the extremities occurred shortly before admission. The patient had been on lithium carbonate 300 mg., five to eight tablets daily, since October, 1975 and hydrochlorothiazide (Hydrodiuril®) 50 mg. daily since 1968 for essential hypertension.

Four months prior to the development of lithium toxicity, he sustained a fracture of the right ankle which required casting for several weeks. Because of persistent pain in the ankle, the patient was given phenylbutazone (Butazolidin Alka®) for six days and continued taking lithium and hydrochlorothiazide. Following the administration of the phenylbutazone, the patient recalled that he was not feeling well.

He had extraction of four teeth two weeks before his admission. Subsequent to his dental extractions, he experienced diminished intake of both fluids and food. This led to significant dehydration, well known to predispose to lithium toxicity.

The system review was unremarkable except for a glucose tolerance test done in 1966 compatible with the diagnosis of

latent (chemical) diabetes. Urines had been checked at regular intervals by the patient at home and always had been negative for sugar. His fasting blood sugars had been within normal range.

On physical examination, his blood pressure was 128/80, his pulse was 80 and regular, and his temperature was 98.6°. His physical examination was unremarkable except for some rosacea of the face and slightly miotic pupils that did, however, respond to light. The neurological examination revealed mild confusion, lethargy, slurring of speech, and slightly unsteady gait.

HOSPITAL COURSE

The therapeutic lithium level has been established as 0.6 to 1.2 mEq/L, and signs of toxicity may appear at levels only slightly above the maximum therapeutic level. The patient's lithium serum level was 3.4 mEq/L on the day of admission, necessitating immediate measures to assess presence of fluid-electrolyte disturbances, hypotension, arrhythmias, and oliguria or anuria.

Chest x-ray, serum SMA-12, serum electrolytes, urinalysis, thyroid study, and serial CPK's were normal. Hydrochlorothiazide and lithium carbonate therapy were discontinued. His blood pressure was checked frequently and remained normal. The patient initially was given one liter of 5 percent dextrose in normal saline intravenously in addition to large amounts of water and other liquids orally. His urinary output remained normal. With the continuation of supportive therapy and encouraging oral fluids, his serum lithium value was 1.1 mEq/l four days after admission; on the seventh day, it had fallen to 0.3 mEq/L.

At the time of hospital discharge, both his sense of taste and appetite had improved greatly. His gait was no longer unsteady, and his dysarthria, confusion, and lethargy had cleared.

During his hospitalization, admission and serial electrocardiograms revealed nonspecific ST depression and T-wave inversions over the anterior precordial leads which gradually subsided as the serum lithium levels decreased (Figures 1, 2). Two weeks after discharge, the electrocardiogram was within normal limits (Figure 3). The blood lithium level at that time was 0.52mEq/L.

Hypomania developed as the patient's lithium blood level dropped below the therapeutic range. At the time of hospital discharge, he was started on lithium carbonate 300 mg., two tablets three times a day. The hypomania subsided over a period of three weeks, and there has been no recurrence of mania or lithium toxicity. His internist started the patient on metoprolol-tartrate (Lo-pressor®) 50 mg., twice a day, following hospitalization, with resultant adequate control of his hypertension.

DISCUSSION

It is notable that the patient remained on lithium (1500 to

The physician should be aware of the possible deleterious drug interactions between thiazide diuretics and lithium. Lithium is reabsorbed with sodium in the proximal tubule.

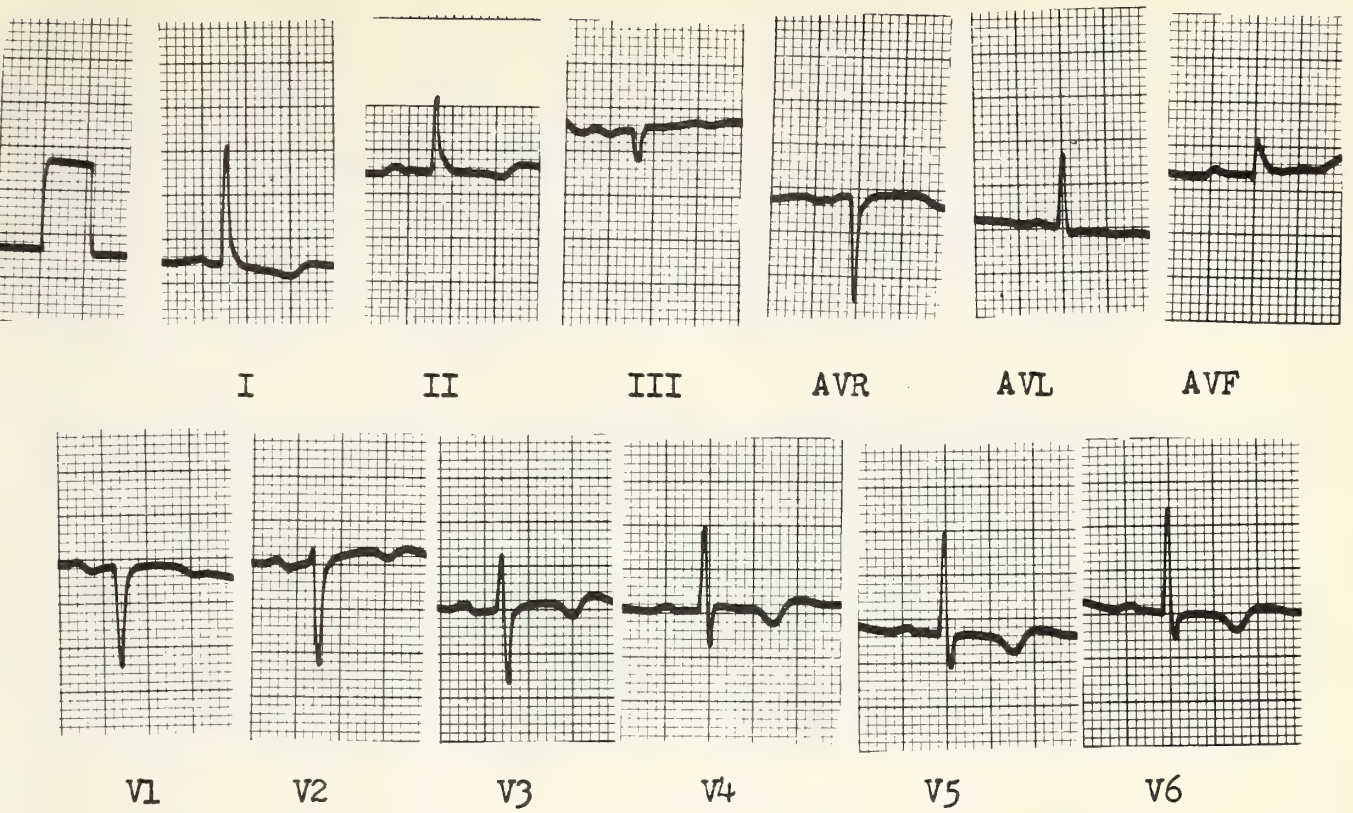


Figure 1—EKG taken upon admission. Blood lithium level was 3.4 mEq/L.

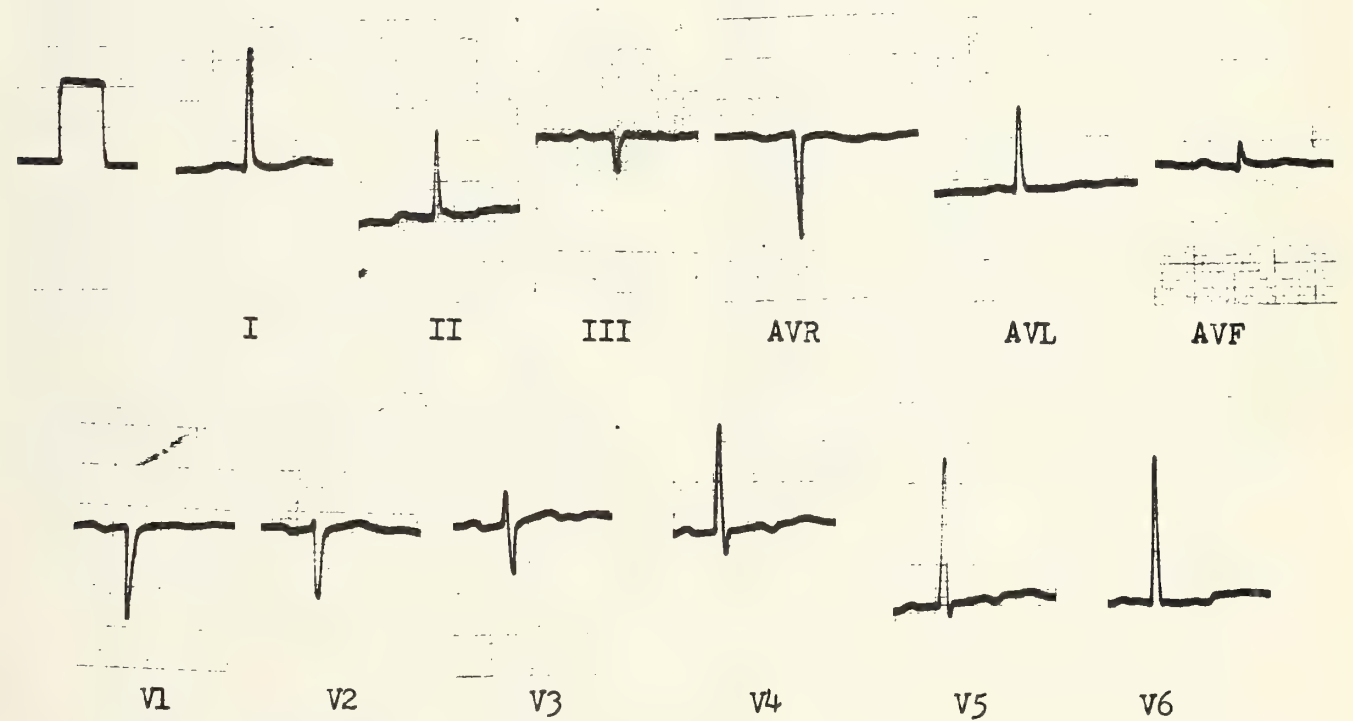


Figure 2—EKG taken seven days after admission. Blood lithium level had fallen to 0.3 mEq/L.

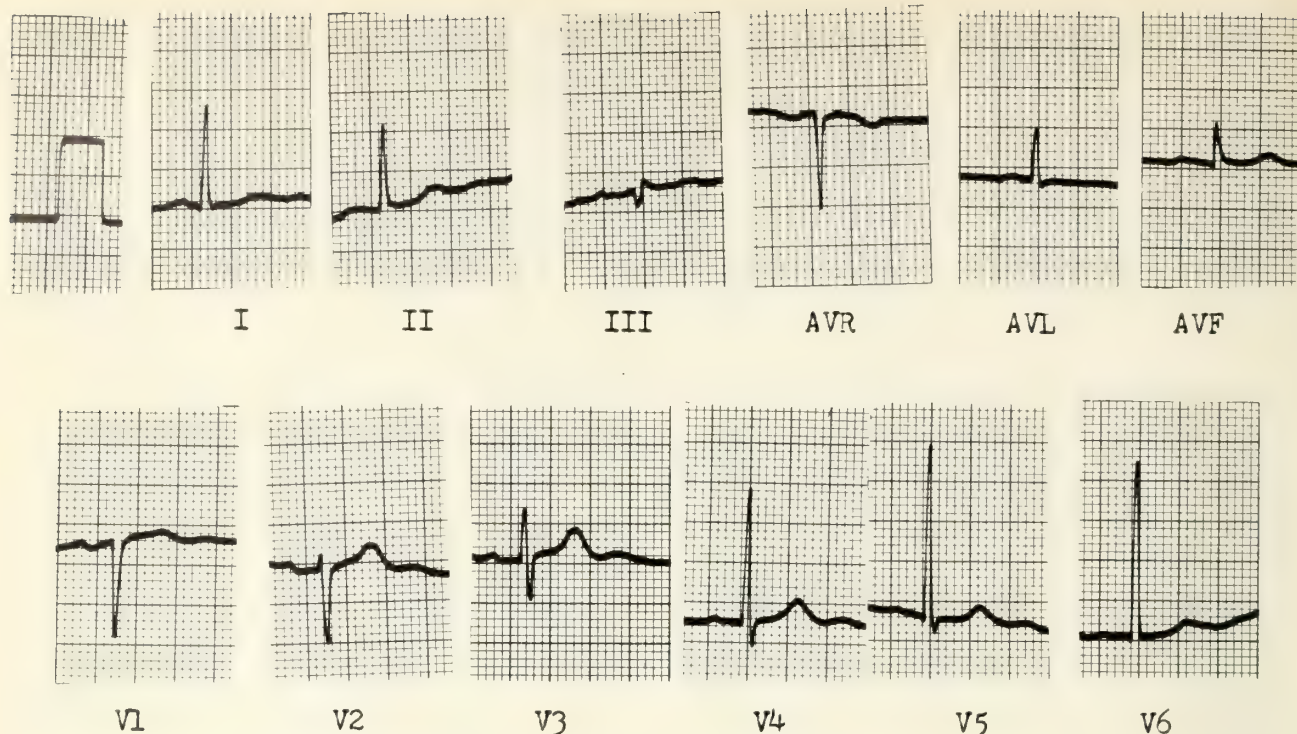


Figure 3—EKG taken two weeks after hospital discharge. Blood lithium level was 0.52 mEq/L.

2400 mg. daily, along with hydrochlorothiazide 50 mg. once a day for three years) uneventfully prior to the development of toxicity. Manic episodes, previously requiring hospitalization, had been well controlled for several years. His last blood lithium level, fifteen weeks prior to this admission, was 0.67 mEq/L.

The lithium toxicity occurred six and one-half weeks after treatment with phenylbutazone and two weeks after the four dental extractions. Phenylbutazone may have interfered with a previous physiological equilibrium regarding renal excretion of sodium and lithium, causing sodium and lithium retention and a mild elevation of serum lithium. Diminished fluid and food intake due to anorexia following the extractions then may have reduced the body fluids, leading to an increasing serum lithium level to the point of toxicity.

Significantly, the patient's wife had managed his medications, and he was not aware of the types of medication he was taking at the time of admission. Furthermore, the patient and his wife had delayed notifying the treating psychiatrist of the patient's symptoms because they attributed them to depression, which he had experienced on several occasions during the years prior to admission.

Diuretic administration may lead to a reduction in renal lithium clearance. A possible mechanism is that during thiazide treatment, sodium excretion equals sodium intake

due to a compensatory increase in sodium reabsorption in the proximal renal tubule. Lithium is reabsorbed with sodium in the proximal tubule. Hence, long-term use of diuretics can lead to an accumulation of lithium and a decrease in renal lithium clearance. Congestive heart failure and salt restriction also can lead to a decrease in lithium renal clearance. Although normal restriction of sodium in the diet poses no problem, a severe restriction in dietary sodium intake results in an increase in lithium retention and risk of lithium toxicity.

Lithium-related electrolyte shifts can affect the T-wave of the resting electrocardiogram⁸. Reversible, minor T-wave flattening and inversion have been reported in about one-fifth of patients on lithium⁹. Potassium depletion and digitalis, which alter the intramyocardial ratio of potassium ions to sodium ions, are thought to cause these T-wave abnormalities.

Tilkian and coworkers studied the effect of lithium on cardiovascular performance¹⁰. They found no adverse effects as measured by treadmill testing. Six out of twelve patients developed T-wave depression in the resting electrocardiogram during lithium therapy. However, lithium failed to induce exercise ST abnormalities. This is important to know when doing stress tests with these patients. Ambulatory electrocardiographic monitoring suggested that ventricular

Long-term use of diuretics can lead to an accumulation of lithium and a decrease in renal lithium clearance.

Treatment of the lithium-toxic patient requires removal of the lithium from the body and correction of dehydration and concomitant electrolyte imbalance.

arrhythmias may, however, be initiated or aggravated by lithium therapy.

Treatment of the lithium-toxic patient requires removal of the lithium from the body and correction of dehydration and concomitant electrolyte imbalance¹¹. The severity of lithium intoxication is related to the serum lithium concentration and the duration of exposure to toxic levels. In the presence of reduced renal lithium clearance due to a negative sodium balance from decreased salt intake or use of diuretics, the patient may be given sodium chloride, 150 to 300 mEq/L over the first six hours. Dialysis should be used if the serum lithium is higher than 4 mEq/L or if the level is between two and four mEq/L and the clinical condition is poor. Particularly in the instance of intentional overdosage, induced emesis and gastric lavage may be used to empty the stomach of any unabsorbed lithium.

CONCLUSIONS

The likelihood of adverse reactions to lithium administration must be considered in relation to the dangers inherent in the psychiatric condition. There is particular risk of toxicity if sodium balance or renal function is compromised. If lithium and thiazide or thiazide-like diuretics are to be used concurrently, the lithium dose may have to be lowered and levels more closely monitored to avoid toxicity. "Loop diuretics" apparently do not elevate serum lithium levels but unfortunately are rarely useful for long-term management of essential hypertension.

The patient and family should be educated carefully regarding the risks and signs and symptoms of lithium toxicity. The authors feel that should antihypertensive treatment be required for patients taking lithium, it would be prudent to consider antihypertensive medications other than the thiazide or thiazide-like diuretics. Medications that have been used with success include propanolol (Inderal®), alpramethyldopa (Aldo-met®), and reserpine.

SUMMARY

Concomitant administration of lithium and thiazide or thiazide-like diuretics which act on the distal convoluted tubule may result in an adverse reaction. The above diuretics reduce renal lithium clearance, increasing lithium retention to potentially toxic serum levels. Development of anorexia, diarrhea, and other causes of dehydration and electrolyte imbalance then may precipitate toxicity.

Frequent symptoms of toxicity include the gradual onset of anorexia, apathy, muscle twitching, ataxia, and dysarthria.

Benign resting EKG abnormalities involving mainly the T-waves are associated with lithium administration which

subside as the lithium level is reduced. Ischemic ST segment depressions have not been elicited, with stress testing patients taking lithium. Arrhythmias, hypotension, and vascular collapse occur in lithium intoxication, but it is unclear whether these are direct or indirect effects of lithium on the cardiovascular system.

Principles of management of toxicity include removal of lithium from the body (gastric lavage may be indicated in the case of acute overdosage) and correction of dehydration and electrolyte imbalance.

There may be 35 million hypertensive patients under treatment with thiazide or thiazide-like diuretics; many thousands of manic-depressive patients are receiving lithium in the United States at this time. A number of patients may be under treatment for hypertension and manic-depressive reaction concurrently, receiving both a thiazide or thiazide-like diuretic and lithium.

When lithium and thiazide or thiazide-like diuretics are used together the lithium dose may have to be lowered and the levels more closely monitored to avoid toxicity. Although recent work reveals "loop diuretics" may not lead to lithium toxicity, these drugs rarely are used in long-term management of essential hypertension. Therefore, when feasible, the physician should consider use of antihypertensives other than thiazide diuretics during lithium administration.

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Elevated Sound Levels in New Jersey Discotheques*

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Sound level measurements obtained in some of New Jersey's most popular discotheques in 1978 demonstrate the existence of music levels which could be detrimental to hearing. The mean sound level (A scale) for thirty-four discos was 104 decibels. Rock band members and individuals who frequent discos with live entertainment often are exposed to sound levels which may produce temporary or permanent shifts in the threshold of hearing.

Discotheque is a word of French origin meaning a place of recorded music; for this study a disco is defined as a nightclub with a floor for dancing. The music may be live or recorded.

Rock music is generally very loud, but there are no published surveys which quantify sound levels in New Jersey discos, and surveys conducted in other states generally provide data on only a few discos.¹⁻⁷ The purpose of this investigation was to measure sound levels to determine if New Jersey discotheques had levels high enough to be considered a public health hazard. A second objective was to determine if newspaper and other publicity about the adverse effects of rock music on hearing had effected a reduction in disco noise levels; previous studies, though limited in scope, had found high sound levels in discos prior to the present survey.¹⁻⁷

METHODS

Sound level measurements were obtained in the discotheques using a type 1565-C General Radio Sound-Level Meter. The meter was portable, 92x165x53mm in size, and 0.45kg in weight. The sound level meter was calibrated with a General Radio GR1567 Sound Level Calibrator. This calibration was performed prior to each visit to a disco, and checked just after leaving the disco. The calibration was done at a sound pressure level of 114 dB @ 1kHz re 20N/m² and with an accuracy at standard pressure and temperature of 0.5

dB. Sound pressure adjustments for temperature were considered insignificant and were not employed.

The discotheques surveyed in the study were chosen from three different sources: 1) the past twelve editions of the *New Jersey Monthly* magazine (nightlife section); 2) friends' and colleagues' recommendations; and 3) newspaper and radio advertisements. A total of 34 popular establishments from twelve of the 21 New Jersey counties were surveyed. These discos are not necessarily representative of all New Jersey discos; however, the discos were not chosen as a result of prior knowledge that the sound levels were unusually high.

All discos were visited without prior notification. The small size of the 1565-C General Radio Sound Level Meter allowed its presence and operation to proceed unnoticed by and undisclosed to the management, band members, or patrons of the discos. If the exposed individuals knew that they were being monitored with dosimetric equipment this could affect their behavior and modify sound level meas-

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urements; therefore a dosimetric investigation on selected disco patrons and/or employees was not performed. Most discos were visited on Wednesday through Saturday between the hours of 9:00 p.m. and 2:00 a.m.

The sound level readings on three scales (A, B, C) using slow response were compiled at three test trials separated by ten-minute intervals. Only the A scale results are reported here, since the A scale is thought to correspond most closely to physiological responses to hearing. Sites for the sound level measurements were chosen so that approximately half of the patrons within the disco were located between the major source of sound and the sound meter. The objective of these sound level measurements was to obtain the mean sound levels at a representative location in the disco. The maximum decibel reading on the A scale was noted in each disco; and the continual background sound from the recorded disco music played between the live band performances also was measured at those discos with live bands. Our own data on threshold shifts resulting from exposure to disco noise will be reported separately.

RESULTS

The mean sound levels found are shown in Figure 1. Figures 2 and 3 provide comparable information on maximum and background disco sound levels. We found that 94 percent of the discos tested had mean levels (average of three readings) of 100 dB (A) or greater; and that 68 percent of these discos had mean sound levels equal to or greater than 105 dB (A). Ninety-one percent of the discos surveyed had continuous sound levels of ninety decibels or more; and 21 percent had a maximum sound level greater than 115 dB (A).

CASE REPORT

A thirty-year-old medical student visited a local discotheque on August 5th, 1978 and spent about 30 minutes quite close to the source of the music with his left ear exposed more than the right. When he left the discotheque he felt hearing impairment, tinnitus, and discomfort in both ears, particularly in the left ear. His hearing remained impaired in the left ear, and he felt that everything sounded as if he were "listening through a tin can." About sixty hours after exposure with persisting symptoms, he sought medical care.

When first seen there were no abnormalities on physical examination. An audiogram showed a bilateral sensorineural hearing loss more marked in the more exposed left ear. In the right ear, a shallow 4000 hertz dip was apparent (Figure 4) but in the left ear a definite threshold shift in the entire audiogram was noted (Figure 5). There was no air/bone gap and tympanometry revealed normal middle-ear air compression and normal middle-ear air pressure. The audiologic profile was consistent with a cochlear lesion.

Symptoms improved in the left ear over the subsequent two weeks and the student was seen on the seventh and tenth day postexposure as well as six months later. Progressive improvement was noted with more apparent improvement in the low frequencies as compared to the highs. Three frequency pure tone averages for the left ear in terms of decibels of hearing threshold loss were 38 at three days, 30 at seven days and 23 at 10 days. At six months the hearing had improved to 20 dB HTL, indicating that most of the recovery had occurred in the first ten days. Figure 5 demonstrates graphically the changes in the air conduction hearing threshold levels in the left ear.

The patient undoubtedly has suffered a permanent loss of hearing as a result of this exposure. He had been tested a

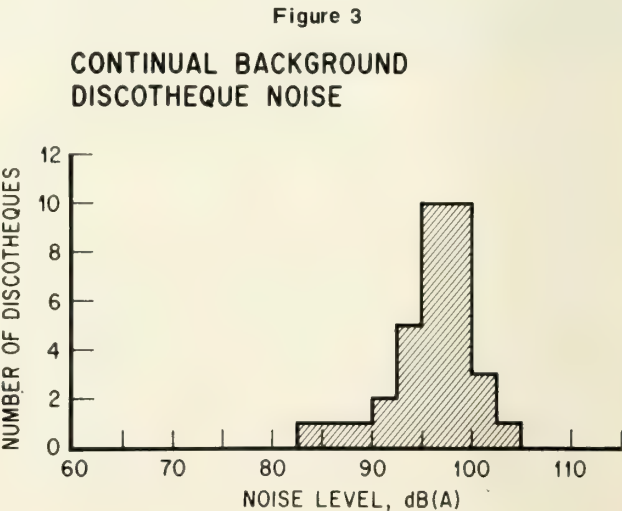
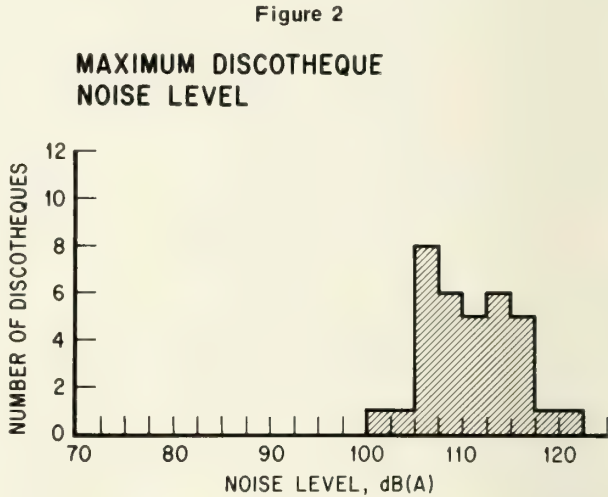
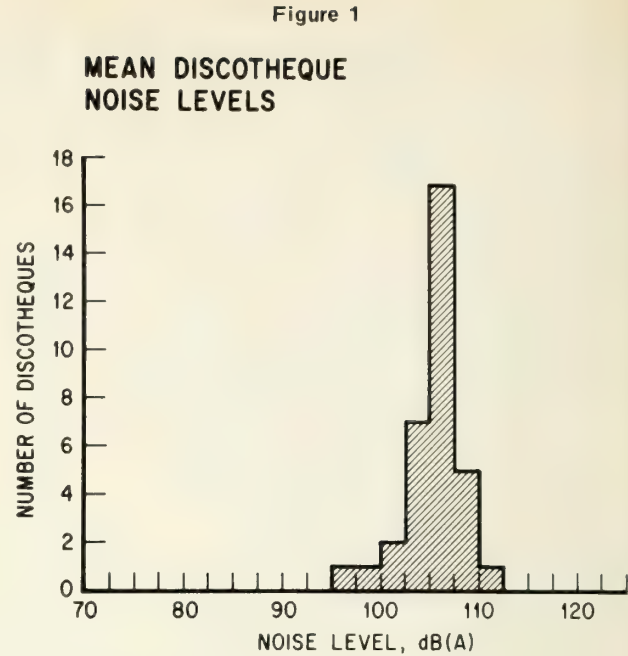


Figure 4

HEARING THRESHOLD SHIFT IN RIGHT EAR

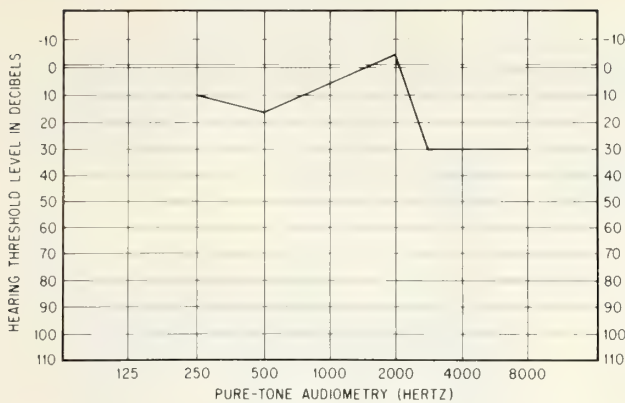
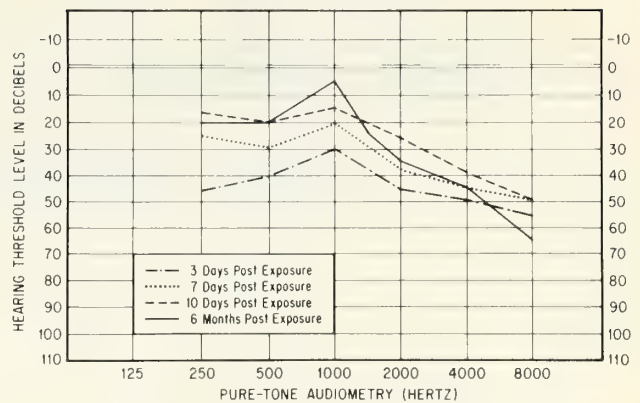


Figure 5

HEARING THRESHOLD SHIFT IN LEFT EAR



number of times before and always had been found to have normal hearing. The residual hearing loss, although not handicapping, demonstrates the potential for auditory damage by present discotheque sound levels.

DISCUSSION

The data clearly show that elevated sound levels are common in New Jersey discotheques and that these levels are high enough to be a potential health hazard.⁸ The degree of damage to the hearing of specific individuals cannot be estimated accurately because of differences in individual susceptibility to sound-induced hearing loss. The degree of hazard is also dependent on the time and intensity of exposure, and this may be quite different for patrons, non-musician employees, and band members. Studies of rock music in the same decibel range as found in this study have demonstrated adverse effects on the hearing of young adults and rock band members. For example, in an experimental study, Dey presented tape recorded music at 100 and 110 decibels by earphone to fifteen young men with normal hearing.² He used a temporary threshold shift of 40 decibels as a damage risk criterion and suggested that after exposure for two hours to rock music at 100 dB, two percent of individuals can expect to have a substantial temporary threshold shift. At 110 dB, sixteen percent will be affected adversely. Speaks found that the noise levels of ten rock bands ranged from 90 to 110 dBA.³ Lipscomb found that exposure to 88 hours of rock music over a two-month period resulted in marked cochlear damage in the guinea pig.⁴ Hanson and Fearn surveyed 505 students and found statistically significant hearing loss in the group that frequently attended establishments with loud rock music in comparison to a control group.⁵ These authors suggested, three years ago, that lower amplification of rock music should be initiated, but our results indicate that this has not taken place in the establishments we visited.

However, Darcy indicated that, although a substantial

hearing loss might be expected in rock musicians, other employees in rock establishments, for example waitresses, generally are not exposed excessively.⁶ For waitresses in the state of Washington, Darcy found that, although their exposure often exceeded 90 dBA when the band was playing, it was frequently less than 90 dBA when averaged over the entire work shift. In contrast, in our survey, even the continual background noise was greater than 90 dBA for 91 percent of the discos.

It is clear that continued and prolonged exposure to sound levels of the magnitude found in this study will increase the probability of elevations of the threshold of hearing. The use of ear plugs by disco musicians, non-musician employees, and patrons may be beneficial in order to minimize this possibility. Standards promulgated in the U.S. Department of Labor's code for occupational noise exposure are based on a maximum average exposure of 90 dBA for eight hours and a five dBA time-intensity relationship,⁸ i.e., four hours at 95 dBA, two hours at 100 dBA, one hour at 105 dBA. These standards should be applied in discotheques.

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The Non-Medical Health Officer—An Appraisal of His Role

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KATHLEEN M. DOYLE, B.A., FRANK FITZPATRICK, M.A., Newark*

This paper reviews the status of the non-medical health officer in New Jersey over a six-year period between 1969-70 and 1975-76 using a detailed questionnaire. The growth of this profession is illustrated from the standpoint of age, income, experience, job satisfaction, and influence upon the community.

Throughout the United States the trend toward non-medical health officers has come about in light of shortages in medical manpower, the expansion of the health industry, and the changing role of health departments. The increasing number of non-medical health officers serving in health jurisdictions, which in the past were the domain of full and part-time physicians, has resulted in identification of a new health profession equally concerned with individual and community health.

New Jersey was among the first states to consider the recruitment of non-medical health officers to administer local health departments. Indeed, the initial health officer licensing law was promulgated in 1947. In order to assess the specific roles and functions of this group, a study was conducted among New Jersey non-medical health officers over a six-year period. The results of this study follow.

METHODOLOGY

In 1969-70, and again in 1975-76, questionnaires designed to elicit data on demographic characteristics, job function, recruitment, job satisfaction, income, and relationships within the health care system were mailed to all non-medical health officers in New Jersey. The roster of licensed Health Officers issued by the New Jersey State Department of Health was used. Responses were received from 26 percent (N=41) in the early sample and 63 percent (N=47) in the latter.

Data were analyzed for the purpose of exploring changes over the six-year period which might answer the question: What is the role of the non-medical health officer in resolving the problems of community health?

RESULTS

First, the data confirm an increase in the territory managed by non-medical health officers (Table 1). The data also show a trend for more non-medical health officers to be under the age of 40 in 1976 (Table 2).

Among the most dramatic changes registered over the six-year period were in the area of income. In 1970, 75 percent of the health officers in the study were earning under \$16,000. This percent changed fivefold in 1976 with only 15.9 percent earning \$16,000 or under, an indication, verified by the report, that salary ranges increased substantially from 1970 to 1976 (Table 3).

Another area of significant change is reflected in the number of years health officers have been involved in public health. In 1970, 14.6 percent of the respondents had been

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When there are conflicting opinions concerning health policies, his expertise may permit the health officer to mediate and recommend acceptable solutions.

employed in public health work for less than ten years as compared to 28.6 percent in 1976. Also, in 1976, 65.3 percent of the respondents had been employed in their present position less than ten years as compared to 53.7 percent in 1970; indicating a trend for the local municipalities to employ a younger, possibly better educated, but less experienced individual.

Interestingly, health officers in the 1976 study group did not differ substantially from the study group of 1970 in responding to the question: "Why is your present position important to you?" In both groups job satisfaction, job challenge, and good income were recorded in that order (Table 4).

In both study groups, the reasons for entering public health work emanate from an initial interest in the medical field. However, among the 1970 group, 17.6 percent stated that they entered the field because their father had been a health officer as compared to 3.8 percent in the 1976 group. Public appointment accounted for 15.2 percent of the 1970 study group and 6.4 percent for the 1976 group. There was little difference in the responses of both study groups concerning influence by a public health worker or a friend (Table 5).

When asked what they saw as obstacles that face a health officer in performing his work, both groups selected the same three major areas of concern: poor communication, inadequate training, and politics. However, the 1976 group changed the order with politics heading the list, followed by communication and inadequate training (Table 6).

There was a consensus regarding the major problem faced by health officers. Both groups agreed that administrative problems and lack of public understanding of their work hinder the performance of their duties. Although both groups agreed that program implementation, political interference, and lack of enforcement are also major detriments, the order in which they selected these differs (See Table 7).

DISCUSSION

In consideration of an analysis of the questionnaire data and the actual experience and observations of the authors, it appears over the six years of the study that the non-medical health officer more frequently is called upon to participate in

making policy decisions together with community groups and other professions. When there are conflicting opinions concerning health policies, his expertise may permit the health officer to mediate and recommend acceptable solutions.

With increased training and experience, the non-medical health officer may be able to anticipate areas of conflict and manage to avoid the emergence of conflicts by carefully identifying the problem areas and offering alternative solutions.

A major role of the non-medical health officer is to maintain congenial relationships among existing bureaucracies. As his ability to do this increases and as the number of full-time trained non-medical health officers increases, the occupation will gain a solidarity and respect. This will increase the ability of the non-medical health officer to express his professional opinion to the State health department and the local board of health concerning health programs and priorities.

We have found that more non-medical health officers recognize that their acceptance in the community as a professional hinges heavily on their involvement in matters of community concern. Therefore, they extend their services to the community by being involved actively in the significant community agencies and by addressing community groups on health problems and programs.

As more federal dollars and programs seep into the health field, the non-medical health officer has become involved in the development, support, and interpretation of health legislation. He has a prime responsibility to make sure that

Table 1
Municipal Jurisdiction

Variable	1970	1976	Percent Change
Management of large Municipality (10,000 population and over)	36.6	44.2	+ 7.6

Table 2
Breakdown by Percent of Non-Medical Health Officers 1970-1976

	1970	1976	Percent Change
Under 40 years of age	13.5	19	+ 6.9
40 - 50 years of age	22	28	+ 6
Over 50 years of age	65	53	-12

Table 3
Income of Non-Medical Health Officers

	1970		1976		Percent Change
	N	Percent	N	Percent	
Under \$16,000	30	73.3	24	15.8	- 59.1
\$16-18,999	4	9.7	35	24.5	+ 17.0
\$19-21,999	3	7.3	40	27.7	+ 20.2
\$22-24,999	2	4.9	24	16.0	+ 11.0
\$25,000 and over	2	4.9	24	16.0	+ 11.0

Table 4
Reason Present Position is Important to Non-Medical Health Officer

	1970	1976	Percent Change
Gratifying Job	23.1	35.6	+ 12.5
Challenge	23.1	32.2	+ 9.1
Good Income	15.3	10.0	- 5.3

Table 5
Reason for Interest in Public Health Work

	Rank Order	1970	Rank Order	1976
Interest in Medical Field	(1)	23.0	(1)	15.4
Father was Health Officer	(2)	17.6	(5)	3.8
Public Appointment	(3)	16.2	(4)	6.4
Public Health Worker	(4)	14.9	(2)	14.1
Friends	(5)	12.5	(2)	14.1

Table 6
Obstacles Non-Medical Health Officers Face

	Rank Order	1970	Rank Order	1976
Poor Communication	(1)	26.2	(2)	30.1
Inadequate Training	(2)	22.6	(3)	14.0
Politics	(3)	16.7	(1)	32.3

Table 7
Problems With Job

	Rank Order	1970	Rank Order	1976
Administrative Problems	(1)	37.3	(1)	22.9
Lack of Public Understanding	(2)	13.6	(2)	20.5
Program Implementation	(3)	6.8	(4)	8.4
Political Interference	(4)	5.1	(3)	19.3
Lack of Enforcement	(4)	5.1	(5)	4.8

sufficient federal and state health dollars filter down into his community. At the same time he also has the responsibility to work closely with the medical profession to see that these dollars are spent to maintain and improve the quality of medical care.

Community involvement engenders community acceptance. Community acceptance on the other hand encourages the expansion of professional status. Over the study period we have seen a substantial increase in educational achievement. For both study groups occupational success was expressed in terms of job and career satisfaction, rather than financial achievement.

CONCLUSION

Based upon our knowledge of health officers' activities over the six-year period, the authors submit the following conclusions.

The non-medical health officer of today has achieved a clearcut professional status. He is younger and earns more than his counterpart in 1970. He manages a large health-care area and is more involved in the local politics of the community. He plays an active role with other professional associations; he is much involved with official agency programs, especially the State department of health; he serves on boards of voluntary health agencies; he participates heavily in the affairs of community service agencies. Like the non-medical hospital administrator, he is beginning to demonstrate that he is capable of administering the complicated health affairs of municipalities.

While at first some physicians questioned the effectiveness of the non-medical health officer, especially in dealing with medical matters, we believe the present practicing physician

finds in him a valuable source of support and a strong ally in the following ways:

1. As health departments become more sophisticated, the non-medical health officer can provide the practicing physician with sound statistics and epidemiological information.
2. As the mountain of health legislation grows, and as organizations such as HMO's, PSRO's and HSA's expand, the non-medical health officer can monitor the effects of these on the practice of medicine.
3. The non-medical health officer can become a link between the physician and the community. He can interpret the physician's role, disseminate health education and prevention programs, and encourage medical examinations for people who are found by community screening programs to be at high risk of developing specific diseases. The non-medical health officer, together with the physician, can identify the community's health needs and then help to get community political and financial support to answer these needs.

The non-medical health officer of today has achieved a clearcut professional status. He is younger and earns more than his counterpart in 1970.

4. As the responsibility of health departments expands into such areas as air pollution, occupational health, nutrition, cigarette smoking, alcoholism, drug abuse and school health, the need for a full-time health officer, who has been trained to marshal the resources commensurate with this expansion, is inevitable. Most physicians, who can devote only part of their time to the health department and who are trained to administer the healing process on a one-to-one relationship, would find it too time consuming to try to cope with the profusion of activities that characterize the modern health department.

While the practicing physician depends upon his relationship with the patient in the treatment of disease, the non-medical health officer's patient is the community—with all of its diversities. This is an area in which he is specifically trained to manage.

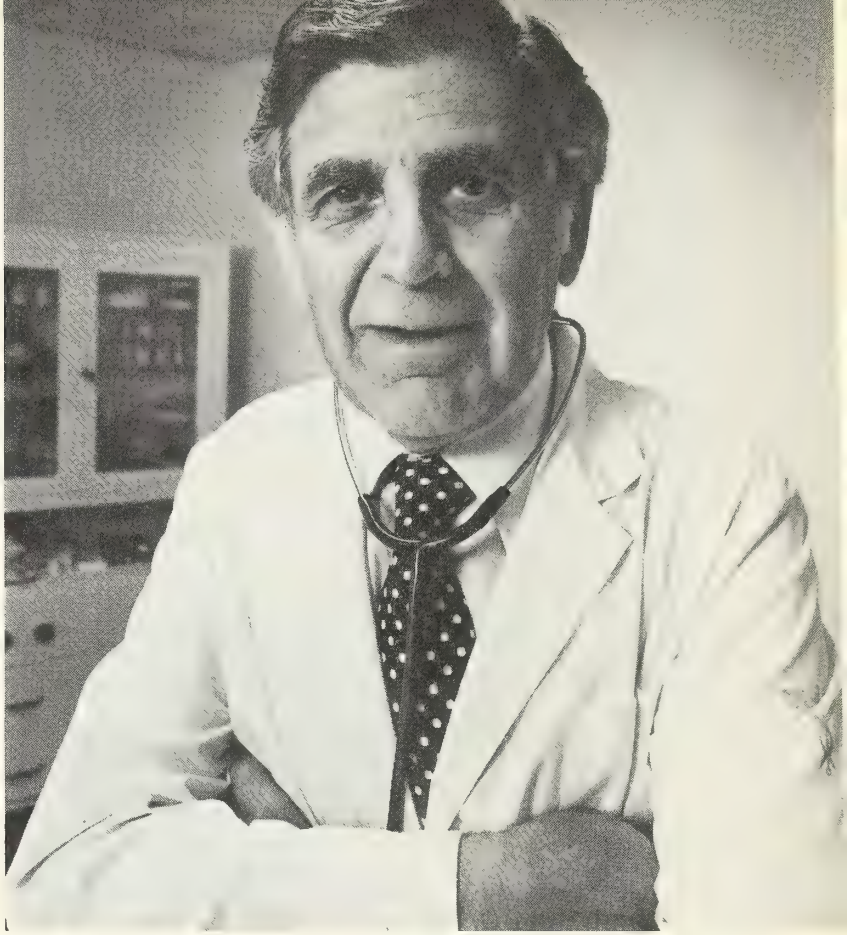
SUMMARY

This paper reviews the status of the non-medical health officer in New Jersey over a six-year period between 1969-70 and 1975-76 using a detailed questionnaire. The growth of this profession is illustrated from the standpoint of age,

While the practicing physician depends upon his relationship with the patient in the treatment of disease, the non-medical health officer's patient is the community—with all of its diversities.

income, experience, job satisfaction and influence upon the community. In brief, the non-medical health officer today is young and earns a satisfactory salary. His job is gratifying; he has become increasingly involved in politics; he has developed a feeling of professional solidarity. In many ways he has become the administrative right arm of the physician in the development and support of health legislation and in the compilation of statistics to provide an epidemiological base for health planning. As respect for his profession develops he becomes a major influence upon the design and implementation of health programs in his community.

“As doctors, we're a key element in the health care cost equation. We order the tests; we decide for or against hospitalizations; we decide when, where and how much treatment is necessary. That's why our active participation in cost-containment programs is vital. Blue Shield's efforts in this area should be encouraged. But the ultimate success or failure of these programs is in our hands because we are the focal point of the system. Let's keep it that way by demonstrating our commitment to cost containment.”



More than anything else, our day-to-day decisions affect health care costs.”

Alfred Alessi, M.D. President,
Medical Society of New Jersey

At Blue Shield, we believe that doctors, and doctors alone, should determine the course of medical treatment. That's why your efforts on behalf of our cost-containment programs are invaluable to us. We need your cooperation. By working together, we know we can achieve our mutual goal: to provide the best health care at the lowest possible cost.



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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Group G Streptococcal Endocarditis in a Patient with Adenocarcinoma of the Colon

HENRY J. ROSE, M.D., STEVEN FISKE, M.D.,
FREDERIC WEISBRODT, M.D., and
LEON G. SMITH, M.D., Newark*

Endocarditis due to Group D *Streptococcus bovis* and now Group G *Streptococcus* should alert the physician to search thoroughly and repeatedly for a bowel carcinoma. This case illustrates this new finding and the importance of detailed speciation of each organism which can provide the lead to search for the underlying disease.

Group G hemolytic streptococcus has been isolated from the human throat, sinus, abscesses, vagina, skin, and feces⁶. Serious infections have been described in the pediatric literature^{4,5} as puerperal infections⁷ and in adults in association with underlying neoplastic disease^{1,2}. A few cases of endocarditis have been reported; most of the patients,^{4,7} but not all, had underlying heart disease^{3,7}. All had good clinical response to penicillin.

CASE REPORT

A 72-year-old male was admitted to Saint Michael's Medical Center with a two-day history of severe frontotemporal headache, fever, chills, and changing mental status. Two weeks prior to admission, the patient experienced an influenza-like illness with generalized malaise, myalgias, and arthralgias. He denied history of rheumatic fever or knowledge of heart murmur. Past medical history was remarkable for a partial colectomy as treatment for adenocarcinoma, descending colon, eight years prior to admission.

On examination the patient had a temperature of 101.8 degrees F, pulse 84, blood pressure 110/70, and respiratory rate of 22. The patient was in acute distress; periods of confusion noted. Diffuse petechial lesions were present on the extremities and trunk. There were splinter hemorrhages in the second digit of the right hand. Marked nuchal rigidity with positive Kernig's sign was noted. A grade III/VI systolic murmur was heard best in the aortic area; it radiated

to the carotids. The liver was tender and palpable five cm. below the costal margin. The spleen was not palpable; there were no conjunctival hemorrhages, Roth spots, Osler nodes, or Janeway lesions. There was no evidence of acute inflammation of any of the joints.

Chest roentgenogram revealed cardiomegaly with clear lung fields. Skull films were normal. Laboratory values included a WBC count of 11,100/cu.mm. with 75 neutrophils, 5 lymphocytes and 23 bands. Hemoglobin was 11.7 gm/dl with hematocrit of 34.9. CSF was cloudy with 3465 WBCs, 100% polymorphs, 180 RCBs; CSF glucose was 50 mg/dl with simultaneous blood glucose 130, the protein was 500 mg/dl. The gram stain and acid-fast stains were negative. Echocardiogram did not reveal vegetations. CSF on the second hospital day was clear with 4 WBC, 16 RBC, protein 103, glucose 57. CSF culture was sterile. Blood cultures subsequently grew gram-positive cocci, later identified as group G streptococcus, sensitive to penicillin, erythromycin, and chloramphenicol. Organism was identified using the Lancefield precipitin technique using Bacto-Streptococcus Antisera, DIFCO Laboratories, Detroit. A sample was sent also to CDC, Atlanta, Georgia, for verification.

*Dr. Rose was a fourth-year student at New Jersey Medical School at the time this study was prepared. Dr. Fiske is Director of Gastroenterology, Dr. Weisbrodt is Director of Neurology, and Dr. Smith is Director of Medicine, St. Michael's Medical Center, Newark. Correspondence may be addressed to Dr. Smith at the Medical Center, 268 High Street, Newark 07102.

The association between severe infection with group G streptococcus and underlying malignancy has been noted.^{1,2} No consistent relationship could be demonstrated between group G bacteremia and host resistance.

A CAT scan later revealed defects in the left temporal and right frontal regions consistent with embolic phenomena. The diagnosis of bacterial endocarditis with emboli and aseptic meningitis was made. The patient showed steady improvement on penicillin therapy. While in the hospital he was noted to have guaiac-positive stools on two occasions. Sigmoidoscopy was performed, and a small friable lesion 15 cm from the anus was biopsied. The pathology report was adenocarcinoma; the patient then was evaluated for surgery.

DISCUSSION

The association between severe infection with group G streptococcus and underlying malignancy has been noted^{1,2} previously. In a review of streptococcal bacteremia at the Massachusetts General Hospital covering the period of November 1964 to October 1966 seven of one hundred fifty-four isolates were due to group G streptococcus. Five of the seven cases were associated with underlying malignancy. These broke down to three cases of breast cancer, one case of cervical cancer, and one case of adenocarcinoma of the bile duct. Sources of infection were reported to be genital tract, biliary tract, pharynx, and skin. There were two cases of endocarditis: one patient had a prosthetic valve, the other had a ventricular septal defect. No consistent relationship could be demonstrated between group G bacteremia and host resistance. All isolates were highly susceptible to penicillin G, erythromycin, and chloramphenicol. Kanamycin was found to be least effective².

Armstrong, Blevins, Louria *et al.* in a review of 600 cases of streptococcal infections at Memorial Hospital for Cancer over the period 1960-68 showed group G streptococcus to be the causative organism in 25.2 percent of the cases. Most of these were wound infections. There were, however, nine cases of well-documented bacteremia in patients with solid tumors. Of these isolates, sources of infection were: gastrointestinal tract (two), upper respiratory tract (three), lower respiratory tract (three), and wound (one). The tumor types were four lymphomas, one mycosis fungoides, one adenocarcinoma ovary, one epidermoid carcinoma of gum, one basal cell carcinoma of the ear, and one metastatic carcinoma of the

Group G streptococcus is an organism that is not highly invasive. Septicemia with Group G streptococcus has been associated with underlying solid tumors, but the specific defect in host defense mechanisms has not been identified.

tongue. Those infections that were treated early responded well to penicillin¹.

Feingold *et al.* in a review of 205 streptococcal isolates at Massachusetts General Hospital reported two cases of group G bacteremia, one of which was proved at autopsy to have endocarditis. The source of infection was most likely the male genitourinary tract; the patient had no evidence of underlying heart disease³.

Ramsey *et al.* described two patients with group G endocarditis occurring in the puerperium; one had no history of previous heart disease⁷.

SUMMARY

Group G streptococcus is an organism that is not highly invasive. Septicemia with Group G streptococcus has been associated with underlying solid tumors, but the specific defect in host defense mechanisms has not been identified. Group G streptococcus is capable of producing endocarditis on normal as well as damaged valves. The organism in virtually all reported cases was highly susceptible to penicillin.

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

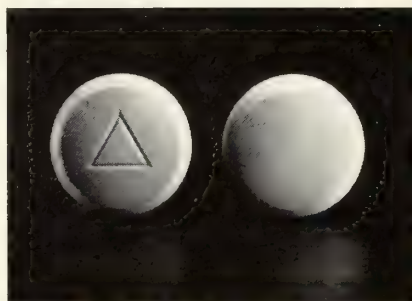
MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

The logo for the Pharmaceutical Manufacturers Association (PMA) consists of the letters 'PMA' in a bold, stylized, serif font. The 'P' and 'M' are connected, and the 'A' is separate.

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Giant Cell Arteritis Involving Uterine Cervix

RAYMOND SCHIFFMAN, M.D., Camden*

Histopathologic examination of a uterine cervix removed from an elderly woman because of descensus revealed giant cell arteritis. Although extracranial involvement by this disease has been reported previously, localization in the uterus is uncommon.

Giant cell arteritis is a condition of unknown cause to which elderly women are prone. Because of its propensity to involve cranial arteries, particularly the temporals, such patients frequently complain of temporal headache and may develop blindness. The disease usually is associated with an elevated erythrocyte sedimentation rate and may be accompanied by anemia, fever, or polymyalgia rheumatica. The synonym, temporal arteritis, has fallen into disfavor because it is recognized that extracranial involvement may occur. Although uterine involvement in this condition is most uncommon, such a case is reported below.

CASE REPORT

A 78-year-old woman was admitted to the hospital because of an incarcerated vaginal pessary. Thirty years previously the patient had undergone supracervical hysterectomy for reasons unknown. One year prior to admission the patient developed urinary stress incontinence and was advised to use a pessary. Subsequent shrinkage of the vaginal introitus resulted in incarceration of the pessary and an associated vaginitis with modest bleeding. The urinary sediment contained many leukocytes and four to five erythrocytes per high power field. Complete blood count, routine chemistry studies, serologic test for syphilis, electrocardiogram, and chest roentgenogram were within normal limits. After attempts at manual removal of the pessary failed, an episiotomy was performed under general

anesthesia and the pessary was removed.

Two weeks later colpopexy, cystourethropepy, anterior and posterior colporrhaphy and suprapubic cystostomy were performed and the cervical stump was excised. The cervix measured 4.5 cm in length and three cm in greatest diameter. It was not remarkable grossly. The entire cervix was processed for microscopic study.

Histologically the cervical stroma displayed nests of lymphocytes and plasma cells particularly under regions of mucosa that had sloughed. Numerous arteries displayed a perivascular infiltrate composed of lymphocytes with few eosinophils. Several arteries displayed granulomatous inflammation of the media or adventitia characterized by the presence of lymphocytes, histiocytes, epithelioid cells, and multinucleated giant cells (Figures 1 and 2). Elastica van Gieson's stain disclosed fragmentation of elastica. In some instances arteries that showed medial destruction also showed medial and intimal fibrosis. No microorganisms were found in stains for acid-fast bacilli or fungi. No birefringent foreign matter was noted when slides were examined under polarized light. After the pathology report on the uterine cervix was received, additional questioning of the patient disclosed that she had a history of temporal

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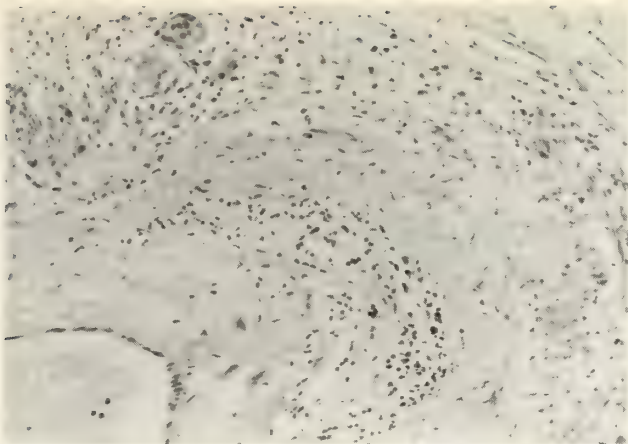


Figure 1—Wall of artery showing granulomatous inflammation. Lumen of artery is at lower left. (Hematoxylin and eosin. Approximate original magnification x 100.)

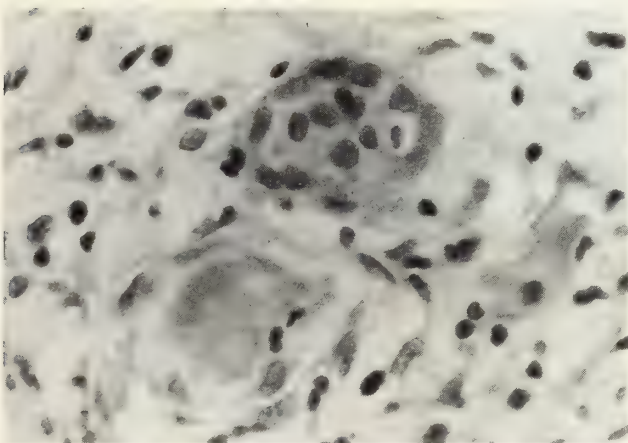


Figure 2—Closer view of figure 1 showing multinucleated giant cells in arterial wall. (Hematoxylin and eosin. Approximate original magnification x 400.)

arteritis which had involved the retinal vessels and had resulted in loss of vision in one eye. The erythrocyte sedimentation rate was 51 mm/hr postoperatively.

DISCUSSION

Ansell *et al.*¹ have described asymptomatic arteritis of the

When the diagnosis of giant cell arteritis is made on uterine tissue, the possibility of extrauterine involvement should be excluded and in patients with systemic involvement, treatment with adrenocortical steroids considered.

uterine cervix in ten women who had no multisystem disease. In these cases, the pathologic lesion was an acute necrotizing arteritis unassociated with giant cells or granulomas and clearly of a different type from that described above. Three cases of giant cell arteritis involving the uterus have been published previously.^{2,3} In one of these cervical involvement was noted also.³ All cases have been in elderly white women whose ages have varied between 66 and 82 years. All suffered from uterine prolapse and all had elevations of the erythrocyte sedimentation rate at least on one occasion. One patient presented with classical polymyalgia rheumatica.³ The disease process in the patient under discussion was said to involve cranial arteries although it is unknown whether such involvement was documented by biopsy. When the diagnosis of giant cell arteritis is made on uterine tissue, the possibility of extrauterine involvement should be excluded and in patients with systemic involvement, treatment with adrenocortical steroids considered.

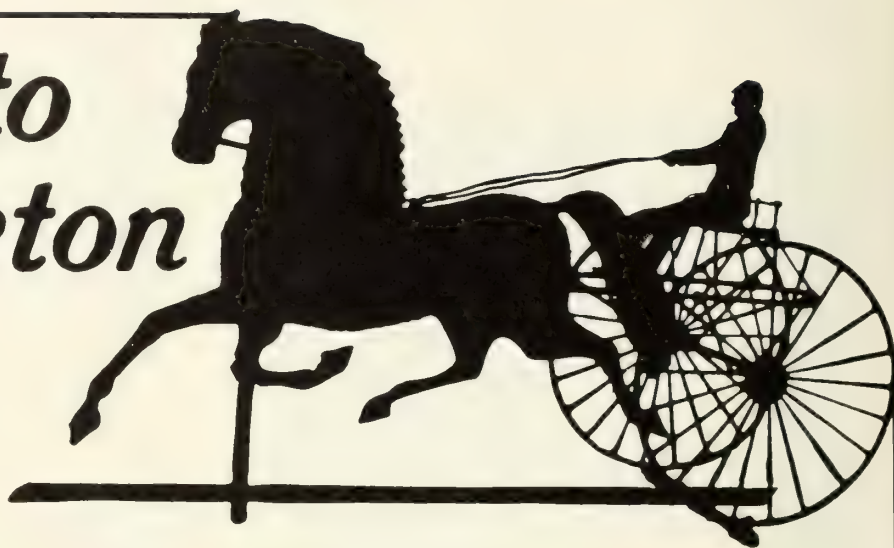
SUMMARY

What is believed to be the second case of giant cell arteritis involving the uterine cervix is reported.

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Valsalva Maneuver-Induced Recurrent Subcutaneous Emphysema of the Face and Neck

SHASHI K. AGARWAL, M.D., Newark*

Valsalva maneuver is usually a benign procedure. This report describes a case where recurrent subcutaneous emphysema of the face and neck occurred in a healthy young male following Valsalva maneuver performed during everyday activities. Air leak from an ethmoidal air cell is proposed as the possible mechanism for its development.

Although Valsalva maneuver is performed in modified forms in everyday activities and physicians in most specialties of medicine use it in their practice, complications associated with it are not well known. Its use has been known to cause sudden death¹, acute proptosis², subconjunctival hemorrhage, skin petechiae, hemorrhagic retinopathy³, and mesenteric vein rupture⁴. Repeated and sustained increases in intrabronchial and intraalveolar pressures may give rise to pneumomediastinum which may extend into the subcutaneous tissues of the face and neck. This may occur as a result of vomiting and retching in diabetic ketoacidosis⁵, straining during the second stage of labor⁶, or due to voluntary Valsalva maneuver as practiced by many marihuana and heroin users⁷. This report describes a case of recurrent subcutaneous emphysema of the face and neck following Valsalva maneuver performed in everyday activities. The purpose of this communication is to call attention to this uncommon but potentially serious complication of Valsalva maneuver.

CASE REPORT

A 25-year-old male was admitted to Bergen Pines County Hospital because of puffiness of the face. The day prior to admission, while exerting pressure to push a door open, he noticed a sudden painful swelling of the left side of his face and neck. Similar episodes had occurred while straining at stool or doing vigorous exercise. The swelling disappeared

spontaneously in all episodes over a period of a few days. The patient's personal medical and family history were unremarkable. On examination the patient was comfortable. The temperature was 98°F orally, BP 120/70 mmHg, pulse regular with a rate of 100/minute and a respiratory rate of 20/minute. There was minimal swelling of the face and neck bilaterally; crepitus could be elicited in the periorbital area, especially on the left side, over the malar region extending to the temperomandibular joints and along the neck up to the suprasternal and supraclavicular areas. There was no sign of any external trauma. Examination of the eyes, ear, nose, throat, and teeth was essentially unremarkable. The jugular veins were not distended. Chest examination was normal. There was no systolic crunching sound audible. Abdominal and central nervous system examinations were normal.

Laboratory investigations, including hemogram and chemistry profile, and electrocardiogram were within normal limits. Chest roentgenogram was normal with no sign of pneumomediastinum or pneumothorax. Roentgenograms of the skull and the paranasal sinuses were normal. Tomograms of the orbits were unremarkable. The patient was treated symptomatically with analgesics. The swelling gradually subsided and the patient was discharged on the seventh day following admission.

*Dr. Agarwal was Chief Medical Resident, Bergen Pines County Hospital, Paramus, NJ 07652. At the present time he is a Fellow in Cardiology at St. Michael's Medical Center, Newark, and may be addressed there—306 High St., Newark, NJ 07102.



Valsalva maneuver-induced recurrent subcutaneous emphysema of the face and neck.

He presented at the hospital again the following day. While straining at stool the swelling of the face and neck had reappeared. Physical examination was essentially unchanged from the previous presentation. Further evaluation during this admission included roentgenograms of the cervical spine, bronchography, and barium studies of the esophagus and the upper gastrointestinal tract, all of which were normal. The swelling gradually subsided and the patient was discharged on the fifteenth day following admission. No source of the subcutaneous emphysema was found and the patient was advised to refrain from performing Valsalva maneuvers.

DISCUSSION

Subcutaneous emphysema may arise from a variety of sources. Probably the most common is a rent in the respiratory tract following thoracic trauma or surgery⁸. Perforation of the alimentary tract may result in soft tissue emphysema anywhere in the body⁹. The facial region usually is involved following traumatic injury or surgery involving the air sinuses or in association with dental procedures. In the extremities it usually results from infections with a gas-forming organism or a rent in the skin as may occur with blast injuries. The extremities are also the most common site of factitious subcutaneous emphysema.

Spontaneous pneumomediastinum and cervical subcutaneous emphysema have been well documented⁴⁻⁷. Most

cases have been associated with diabetic ketoacidosis, second stage of labor, or with marihuana and heroin usage. It generally is believed that increases in intraalveolar pressures lead to alveolar rupture with dissection of air along the vascular sheaths to the media stinum and from there onward into the soft tissues of the neck. Although usually benign and non-progressive, this problem carries a potential for serious complication. Extension may involve the pericardium and may be recognized by systolic crunching sounds on auscultation. Actual compression of the great vessels, trachea, or esophagus may occur. Rupture of the pleura may result in pneumothorax which may be bilateral.

Extensive investigations in this patient failed to disclose any source for the subcutaneous emphysema. Although the episodes were associated with Valsalva maneuver, no air could be demonstrated in the mediastinum. The initial appearance of the emphysema around the left eyelid further casts a doubt on the hypothesis of a mediastinal extension. Valsalva maneuver increases pressures in the paranasal air sinuses and it is possible that rupture of an ethmoidal air cell may have caused the facial emphysema in this patient. This mechanism was thought to have caused ptosis and proptosis in a patient.²

Although Valsalva maneuver commonly is performed, its association with subcutaneous emphysema of the face and neck is uncommon. It is hoped that the earlier recognition of this etiologic association will obviate extensive workup, especially when this condition is seen in otherwise healthy, young adults.

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Plasmacytoma of the Head and Neck

MARK LEVEY, M.D., Livingston*

Plasma cell proliferative disease is a malignant process which may be either localized or generalized. The head and neck region is the most common site for soft tissue lesions. An illustrative case is presented.

The plasma cell¹² is a large spherical cell possessing abundant deep blue cytoplasm and an eccentrically placed rounded nucleus containing dense masses of chromatin. The origin of the cell and its life cycle are still obscure. Some believe it derived from the lymphocyte; others feel it may arise from reticular or blast cells. Plasma cells rarely are found in the peripheral blood, but are abundant in many interstitial tissues and in areas of chronic inflammation. These cells are involved actively in immune mechanisms, and there is considerable evidence of antibody formation by plasma cells.¹² The cells are of morphologic and physiologic diversity and are capable of synthesizing all classes of immunoglobins. The disproportionate proliferation of one or more clones of plasma cells characteristically is associated with the elaboration of excessive quantities of these protein molecules. The globulins may be composed of either heavy or light chain polypeptids, or both, and characteristically remain qualitatively unchanged throughout the course of the plasma cell dyscrasia.⁸ Plasma cell neoplasia is a malignant proliferative process of plasma cells in which the disease may present as a solitary bone tumor, a soft tissue mass (extramedullary plasmacytoma) or as a generalized process (multiple myeloma). In the latter form it is common to find a homogenous M-type protein (monoclonal myeloma type protein). The disease may be encountered first as a localized form, but continued observation will show extension of the malignant process to a systemic form. Never-

theless, making a diagnosis regarding a specific classification is of importance since the prognosis differs depending upon location. When the protean manifestations of the generalized disease are present with a positive bone marrow, chemical evidence of abnormal protein in the body fluids, and radiographic evidence of bone invasion, the diagnosis of systemic plasma cell disease is apparent (multiple myeloma). When, however, the tumor is primarily in soft tissue or solitary bone, the subject becomes more confusing. Is the soft tissue lesion just a forerunner for the systemic disease? In some cases, obviously, yes; however, in many, the disease runs a benign course without evidence of generalized involvement. Confusion also arises when multiple soft tissue sites are involved as to whether one should be considered a primary and the other sites secondary or metastatic; or is this truly a multi-focal disease?

The case described below illustrates the relatively benign nature that the extramedullary plasmacytoma of the head and neck may exhibit; although in this case, the presenting event was almost fatal. It also suggests that more extensive and sophisticated methods of protein analysis will provide positive evidence of abnormal proteins even in extramedullary disease.

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Plasma cell neoplasia is a malignant proliferative process of plasma cells in which the disease may present as a solitary bone tumor, a soft tissue mass (extramedullary plasmacytoma) or as a generalized process (multiple myeloma).

The plasma cell pattern apparently is identical microscopically in all forms of this disease, generalized or localized, with aggregates of plasma cells in fine reticular networks.

CASE REPORT

A 54-year-old female was admitted to Newark Beth Israel Medical Center on March 2, 1977. The day prior to admission, the patient noticed progressive dyspnea such that she presented for admission in acute respiratory distress. She hurriedly was admitted to the intensive care unit where an endotracheal tube was passed with difficulty. During intubation, an obstructing mass was seen in the supraglottic region. Following intubation, the patient was examined and found to have a large pedunculated mass not only in the hypopharynx, but in the nasopharynx and in the nasal cavities as well. The patient then was taken to the operating room, and under general anesthesia, the upper aerodigestive tract was examined. A large smooth pedunculated mass was found attached to the left side of the aryepiglottic fold and easily was removed with a sharp cup forcep. Following removal of the mass, the airway was considered adequate, and the patient was extubated. There was no postoperative respiratory problem.

In 1971, at another hospital, a nasal polypectomy had been performed with the pathology report showing an inflammatory nasal polyp. The patient apparently did well until 1974 when she presented at still another hospital with nasal obstruction. At that time, a nasal mass was removed, and a diagnosis of extramedullary plasmacytoma was made. The patient, however, was lost to follow-up. She apparently felt relieved by the removal of the nasal mass and was not troubled by nasal obstruction or by any respiratory difficulty until the present episode.

Pathological report of the tissue taken from the larynx at the present time showed a plasmacytoma. (See figure 1.) An extensive medical evaluation then followed. This included a complete blood count, complete blood chemistries including total proteins, serum calcium, and alkaline phosphatase which all were within normal limits. Liver and bone scans were negative, and the skeletal bone survey also was negative. Bone marrow studies were within normal limits. Serum electrophoresis showed an elevated gamma globulin and serum immunoelectrophoresis showed IGG lambda monoclonal spike. Urinalysis was normal, and there was no Bence-Jones protein found. Direct and indirect Coombs test was negative. Chest x-ray and barium swallow were also negative. Paranasal x-rays showed opacification of the maxillary and ethmoid sinuses along with cloudiness of the nasal cavities. (See figure 2.)

On March 18, 1977, through a Caldwell-Luc approach, bilateral antrectomies including ethmoidectomy and removal of nasal masses were carried out under general anesthesia. Masses of tissue were found in both maxillary sinuses and in both nasal cavities eroding the lateral walls of the nose and infiltrating the mucosa of the ethmoid sinuses as well. These masses did not appear to invade the bone, but appeared to destroy by expansion, not infiltration. A large pedunculated

mass also was removed from the midline of the nasopharynx. Histology of these various masses was identical with that of the mass removed from the larynx. Postoperatively, the patient did well. She was given radiotherapy, 3500 R to the nose, sinuses, nasopharynx, oral pharynx, and larynx through two separate ports. Following resolution of the swelling due to surgery and radiotherapy, the patient had a clear intact nasal membrane as well as membranes of the nasopharynx and hypopharynx. The patient then was discharged asymptomatic to be followed as an outpatient.

DISCUSSION

Solitary or multiple soft tissue disease involves a proliferation of plasma cells producing pedunculated or sessile masses, either smooth or nodular, most frequently in areas of the body of plasma cell concentration. Thus, the head and neck region is the most common site for soft tissue lesions. The plasma cell pattern apparently is identical microscopically in all forms of this disease, generalized or localized, with aggregates of plasma cells in fine reticular networks. Serum and urine electrophoresis and immunoelectrophoresis reveal the variations in the protein concentration and the anomalous proteins produced by the plasma cell disease. These abnormal globulins designated as the M-Component or M-Spike are found in over 80 percent of cases with generalized disease.¹³ In reviewing 860 cases of multiple myeloma, Kyle⁶ found monoclonal proteins in over 75 percent of the patients with generalized disease. He found approximately 50 percent of these patients having Bence-Jones protein in the urine and 15 percent of his patients having near normal serum electrophoretic patterns. In this series, after one year's follow-up, 66 percent of the patients were alive. After five years, 18 percent were alive with a 22-month median survival for the entire series.

Extramedullary plasmacytoma is an unusual variant of plasma cell proliferative disease and constitutes one-half percent of all the malignant tumors of the upper respiratory tract. Of the 161 reported cases of extramedullary plasmacytoma reviewed by Dolin and Dewar², 78 percent were in the upper respiratory tract excluding conjunctival lesions. The average age was 57 years with most cases falling between 40 and 70 years of age with males predominating about two to one. The lesions were found in the nasal and sinus cavities, the nasopharynx, oral pharynx, and larynx. According to Helms⁵, 66 percent of the cases of extramedullary head and neck plasmacytoma are found in the nose, nasopharynx, and sinus.

Symptoms depend on location with nasal obstruction, epistaxis, hoarseness, and dysphagia being the most prominent. In the cases reviewed by the above authors, laboratory studies were not extensive. Bone marrow aspirates were negative for myeloma cells, and serum and urine protein studies were all within normal range. Treatment was primarily

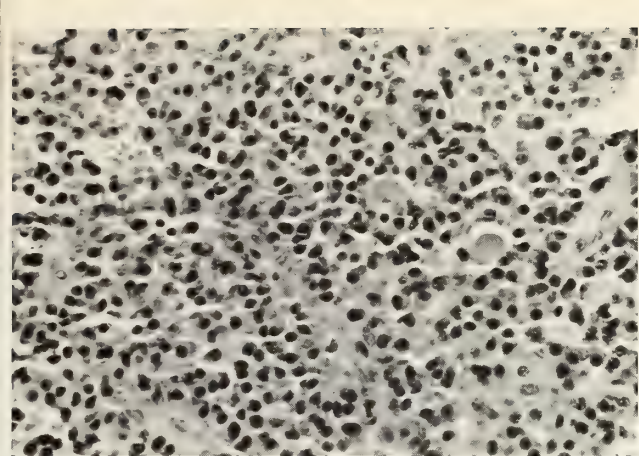


Figure 1—Aggregates of plasma cells infiltrating interstitial tissue characteristic of plasmacytoma.

ly local electrocoagulation alone or in conjunction with irradiation. Survivals generally were good with 10 to 15-year survivals not unusual. Lymph node involvement ranged from 10 to 25 percent, but it did not appear to affect the survival. It is interesting to note that when multiple myeloma appears as the initial problem, lymph node involvement is unusual. The presence of amyloid found in six patients also did not affect survival. Bone destruction appears to be an ominous sign as reported by Webb¹⁰, Hellwig⁴, and Ewing and Foote.³ Cases of solitary lesions reviewed by Webb¹⁰ and by Dolin and Dewar² show negative bone marrow findings as well as negative x-rays of long bones and absence of abnormal proteins in the serum. They stressed that although the solitary lesions in the soft tissue may be the forerunner of systemic disease, these two entities should, nevertheless, be separated. Castro¹ reports 24 cases and reviews 102 other cases of head and neck plasmacytoma. Of his 24 cases, the five-year survival has 53 percent. His cases were treated with surgery and radiation, and he stresses that the extent of disease is more important prognostically than the mode of therapy. Poole⁷ also stresses that location and extent of disease is most important. He recommends radiation as the primary modality of therapy. He points out that when multiple myeloma follows a solitary plasma cytoma, the prognosis is better than when multiple myeloma is diagnosed initially. This would add support to Dolin and Dewar's² contention that these entities should be separated, at least in thought. Stout⁹ emphasizes that nodal and bone marrow metastases are more frequent while internal organ metastasis is exceptional. Ewing³ in an attempt to summarize this confusing problem, states that this malignant process of plasma cells, which may show solitary bone lesions, solitary or multiple soft tissue lesions, or may be generalized, is truly one disease with many variations.

SUMMARY

Plasma cell proliferative disease is a malignant process, which may be localized or generalized. The localized form may be solitary or multifocal and may not produce sufficient abnormal protein as to be detected in the body fluids. The head and neck region with its abundant lymphoid tissue is the most common site for solitary plasmacytoma exclusive of bone. Signs and symptoms are thus related to local structures. The localized soft tissue variety tends to be "more benign" and can be treated by surgery and/or radiation with reasonable survival rates. The forms which present as



Figure 2—Water's view of paranasal sinuses showing almost complete opacification of maxillary and ethmoid sinuses with bone destruction.

solitary lesions and progress to disseminated disease also have a more favorable outcome.

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**WE'RE FIGHTING
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The Low Voltage Syndrome

EDWIN L. ROTHFELD, M.D., Newark*

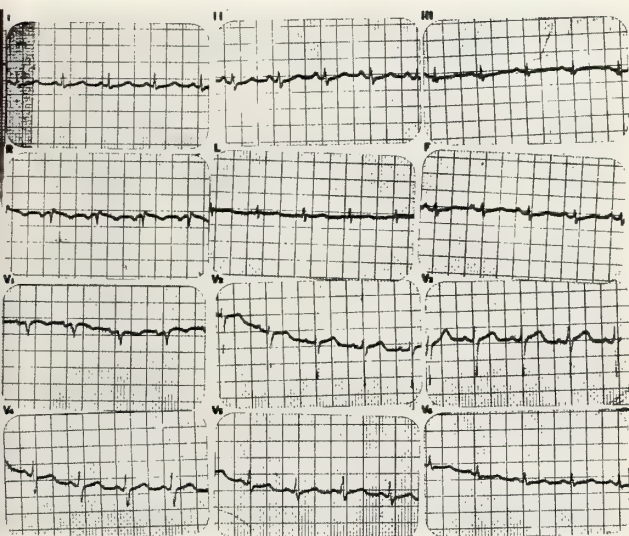


Figure 1—ECG May 15, 1975.

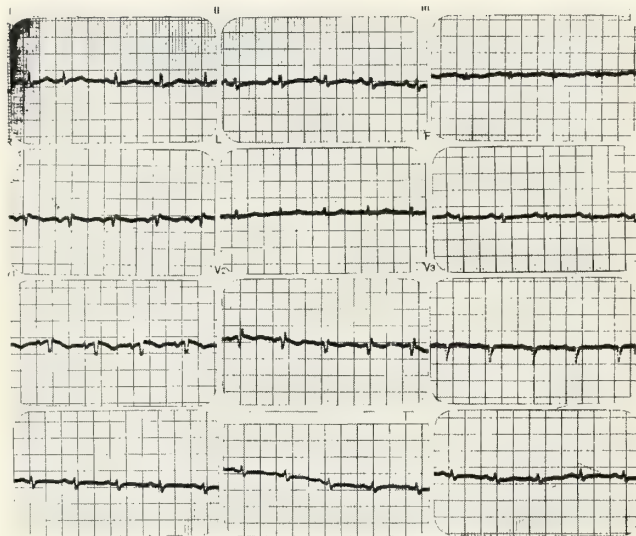


Figure 2—ECG April 25, 1977.

These ECGs, taken about two years apart, show a remarkable reduction in QRS voltage as well as global alterations in repolarization. This 58-year-old woman died of widespread melanoma shortly after the second ECG was obtained. Autopsy revealed massive, hemorrhagic pericardial effusion and extensive replacement of myocardium by metastatic tumor.

DISCUSSION

Abnormally low QRS voltage has been defined by the New York Heart Association as an overall QRS amplitude of less than five mm. in limb leads and less than ten mm. in precordial leads. This configuration is seen in a variety of states related to replacement of functioning myocardial fibers by foreign tissue or to reduction in manifest voltage by "insulating" factors such as pericardial effusion or chest wall obesity (table).

In most cases, the low voltage ECG shows minor or nonspecific changes that are of little value in differential diagnosis. Fortunately, many of the entities listed in the table can be distinguished on clinical grounds. On the other hand, some instances of the low voltage syndrome have fairly specific ECG findings. In extensive cardiac amyloidosis, fine atrial fibrillation, QRS prolongation, and "septal sparing" (normal voltage in septal leads V₁ to V₃) are seen. In

myxedema, sinus bradycardia and QU prolongation are characteristic.

The low voltage ECG of advanced ischemic cardiopathy may show Q waves and ischemic ST-T changes. Trifascicular intraventricular blocks and low voltage are typical of Chagasic myocarditis.

A sudden reduction in voltage speaks for rapidly accumulating pericardial effusion, while the presence of electrical alternans usually indicates a neoplastic origin of the effusion. Another cause for a relatively rapid decrease in voltage is rejection of a cardiac transplant where the ECG demonstrates the typical rejection "tetrad" of atrial fibrillation, right axis deviation, QRS prolongation, and low voltage.

Low voltage in limb leads with normal voltage in chest leads is a characteristic finding in emphysema. Low QRS voltage, right atrial P waves, and incomplete right bundle branch block have been identified in Ebstein's anomaly of

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the tricuspid valve. An ECG with low voltage that is otherwise normal may be found in chest wall obesity. Extremely low voltages often resembling a straight line recording are present in terminal cachexia related to advanced malignancy.

Finally, one must always keep in mind a common, artificial cause of low voltage—inadequate standardization of the electrocardiograph.

Etiology of the Low Voltage Syndrome

A. Congenital

- (1.) Ebstein's anomaly of the tricuspid valve
- (2.) Uhl's anomaly (parchment heart)

B. Inflammatory

- (1.) Phosphorus poisoning
- (2.) Radiation
- (3.) Chronic rheumatic fibrosis
- (4.) Rheumatoid cardiopathy
- (5.) Cardiac transplant rejection
- (6.) Sarcoidosis

C. Infectious

- (1.) Viral (with and without pericardial effusion)
- (2.) Chagasic myocarditis
- (3.) Trichinosis
- (4.) Schistosomiasis
- (5.) Enterobiasis
- (6.) Q fever

D. Metabolic

- (1.) Amyloidosis
- (2.) Hemochromatosis
- (3.) Myxedema
- (4.) Gouty diathesis
- (5.) Mucopolysaccharidoses
- (6.) Lipodystrophies
- (7.) Cachexia and anemia
- (8.) Drugs (Mellaril[®])

E. Neoplastic (with and without pericardial effusion)

- (1.) Secondary
 - a) Lung
 - b) Breast
 - c) Reticulo-endothelial
 - d) Melanoma
 - e) Carcinoid
- (2.) Primary
 - a) Rhabdomyosarcoma
 - b) Fibrosarcoma
 - c) Myxoma

F. Ischemic

- (1.) Vascular
 - a) Atherosclerosis
 - b) Periarteritis and other vasculitides
 - c) Thromboangiitis obliterans
 - d) Diabetic microangiopathy
 - e) Hemoglobinopathies
- (2.) Nonvascular
 - a) Sticky hemoglobin syndrome
 - b) Deficient enzymes (SDH, Cytochromes)

Vegetarianism

JOHANNA DWYER, D.Sc., Boston*

It is possible to be a vegetarian and enjoy a nutritionally sound diet with careful planning. And there, indeed, may be some positive health benefits to such regimens. However, owing to lack of planning, a small group of vegetarians consume diets that are nutritionally incomplete which jeopardize their nutritional status.

Vegetarianism is the consumption of a diet composed predominantly of plant foods. In the United States today, vegetarians make up probably less than one percent of the total population. While it is not a widespread eating style, vegetarianism has grown more prevalent in the last decade, particularly among young adults. Reasons for being vegetarian are generally philosophical, religious, or health-related, rather than cultural or economic.

Vegetarians can be classified according to the types of animal foods left in their diets. Pure vegetarians consume plant foods only—no red meat, poultry, fish, seafood, eggs, or dairy products. Some vegetarians eat only raw plant food. The term *vegan* is used in this newsletter to identify pure vegetarians; it also sometimes refers to people who not only eat pure vegetarian diets but also share a philosophy and life style. The followers of the Zen macrobiotic diet advance through ten stages of progressive dietary restriction aiming ultimately at a diet composed only of cereals.

Lacto vegetarians eat plant foods as well as dairy products. This form is practiced by groups such as Hare Krishnas, some yogic groups, and Trappist monks. Lacto-ovo vegetarians eat plant foods plus dairy products and eggs. Many Seventh-Day Adventists practice this form of vegetarianism, abstaining only from those animal foods they regard as being obtained by destroying life. A variety of other vegetarian patterns also exists. The semi-vegetarian, for example, may eat seafood and/or poultry.

Fully 92 percent of the vegetarian adults surveyed for a recent study claimed additional dietary habits unrelated to the vegetarianism. Some add foods they believe to have special health-promoting or disease-preventing properties such as miso, ginseng, tofu, tempeh, certain herbal teas, and so on. Others add vitamin-mineral supplements or specially fortified products.

HEALTH EFFECTS OF VEGETARIANISM

Many individuals and population groups have practiced vegetarianism on a long-term basis and have demonstrated excellent health. In contrast, the dietary status of Hare Krishnas, followers of Zen macrobiotics, yogic groups, and

others only now is being documented. The diets of these vegetarians are of greatest concern to nutritionists and physicians. Without a food record, laboratory test, and medical examinations needed to determine nutritional status, dietary adequacy or inadequacy is difficult to evaluate. And the diets of newer vegetarians are so heterogeneous that most generalization is hazardous.

One generalization which can be made about dietary deficiency is that the risk is greatest when a pure vegetarian diet is combined with additional self-imposed limitations. Such limitations include minimizing the variety of foods, avoiding fortified or enriched foods or appropriate vitamin-mineral supplements, and maintaining negative attitudes toward Western medicine. Dietary patterns and restrictions like these are particularly hazardous to vulnerable groups such as pregnant or lactating women, infants, growing children, adolescents, and people who are ill or recovering from disease. Dietary deficiencies of greatest concern are those related to energy, protein, iron, and vitamins D (among infants and children), B-12 and B-2. Shortfalls also may occur for intakes of minerals such as calcium, zinc, magnesium, and iodine.

Sufficient energy intake is rarely a problem among adult vegetarians. In some of the newer vegetarian groups, however, infants and children are smaller and grow more slowly than those from less restrictive vegetarian groups and from the general meat-eating population. One possible reason is that pure vegetarian diets tend to be so high in bulk that they may not meet caloric needs of children. Related illness or parental feeding practices also may have an influence. Protein-calorie malnutrition is exceedingly rare but has been reported in a few cases. Because of decreased energy intakes, protein is used by the body as an energy source. Thus, protein content of these restricted diets may not meet the Recommended Dietary Allowances (RDA).

Assuming energy intakes are adequate, combinations solely of plant food can be satisfactory for the growth of infants and young children. The quality of vegetable proteins in the diet is improved by combining those legumes having a high concentration of certain amino acids with grains providing

*Reprinted with permission of *Contemporary Nutrition* 4:6 (June) 1979, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Dwyer is Director, Frances Stern Nutrition Center, New England Medical Center Hospital, and Associate Professor, Departments of Medicine and Community Health, Tufts Medical School, Boston.

complementary amino acids. For example, cereal grains, which are low in the essential amino acid lysine but adequate in methionine, are complemented by legumes having adequate lysine but too little methionine. The overall value of the protein mixture is even better if a small amount of higher quality animal protein, such as milk, is included. With careful planning, however, even diets solely of plant foods can be satisfactory with respect to protein. Mono-diets, such as those based on only one cereal grain should be avoided, especially in feeding young children.

Lacto-ovo vegetarians rarely suffer from vitamin B-12 deficiency since milk and eggs are relatively high in this nutrient. Some vegetarians who have ingested low levels of vitamin B-12 appear to maintain good health for many years without developing overt signs of deficiency while others develop signs in a shorter time.

Vegetarians who avoid all animal foods should be urged to use fortified soybean milks and fermented soybean foods, known to be high in vitamin B-12 or vitamin B-12 supplements. Vitamin B-12 deficiency can be difficult to detect because the relatively high folic acid intakes of vegetarians may mask the characteristic anemia associated with the deficiency. And early detection is important since the neurological aftereffects are not always reversible.

Reports of vitamin D deficiency among vegetarian adults are rare. We can assume they obtain sufficient vitamin D from dairy products or that they are out of doors enough to get the vitamin D they need.

Infants and rapidly growing children appear to be more sensitive to dietary shortages of vitamin D. There have been several reports of nutritional rickets among infants fed macrobiotic diets and among other children subsisting on pure vegetarian diets which are nearly devoid of milk products. This can be prevented by using water-soluble vitamin D preparations, cod-liver oil or liberal amounts of dairy products fortified with vitamin D.

While vegetarian diets, especially those with no milk products, may be low in riboflavin (B-2), overt deficiency disease is rarely reported. The same is true for other vitamins. If a diet is bizarre enough, however, almost any deficiency might be observed. Recent reports include scurvy induced by deficiency of ascorbic acid and xerophthalmia induced by vitamin A deficiency.

Studies of adult vegetarians suggest that in most cases they are ingesting adequate calcium. Lacto vegetarians and lacto-ovo vegetarians rarely suffer calcium deficiency since milk is high in calcium. Pure vegetarians also can achieve adequate calcium intakes by regularly consuming sizable servings of leafy green vegetables, legumes, fortified soybean milks, peanuts, almonds, and sesame seeds. In pregnancy and lactation, however, calcium and vitamin D supplements may be necessary to meet increased dietary needs.

IRON

Among meat eaters and vegetarians alike, there is a high incidence of iron deficiency anemia and iron malnutrition which is most likely to be seen among those who have the greatest iron needs—infants, young children, and pregnant women. Iron deficiency and malnutrition are probably slightly more common among vegetarians than the general public, especially those vegetarians who do not include iron rich foods or iron supplements in their diets.

Nutrition experts believe that phytate (inositol hexophosphate) in whole grains may inhibit absorption of iron and other minerals. In addition, red meat and other flesh

foods, which enhance iron absorption, are not part of the pure vegetarian diet. Ascorbic acid, which is generally quite high in vegetarian diets, may help minimize iron deficiency by improving the bioavailability of plant iron.

As with iron, vegetarians can suffer zinc deficiency because of low intake as well as the lack of bioavailable plant zinc. Animal foods, generally considered to be good sources of zinc, may be omitted from some types of vegetarian diets. And the phytates in whole grains also may make the zinc biochemically unavailable.

Recently, several studies have been published among both nonvegetarians and vegetarians which revealed zinc deficiencies or low serum zinc levels, and even the presence of zinc responsive growth failure. In other countries, studies demonstrate zinc deficiency among children subsisting on vegetarian-like diets high in whole grain cereals. A study of Trappist monks provides evidence of low, although normal, serum zinc and serum magnesium levels. Our own unpublished observations among macrobiotic children eating vegetarian-like diets also had low but normal serum zinc levels and hair zinc values.

Vegetarianism has been credited with minimizing obesity, cancer, coronary artery disease, dental problems, adult-onset diabetes mellitus, diverticular disease of the colon, and a number of other diseases. In all too many cases, the lack of available data prohibits verification.

We can begin to make generalizations about only a few aspects of vegetarians' health status. For example, vegetarians, especially those who abstain from all animal foods, generally have lower weights for their heights than non-vegetarians. Compared to meat eaters, vegetarians are less likely to suffer from the atonic form of constipation.

Epidemiologic data indicate a possible association between risks of colon and breast cancers and the Western world diet which is generally low in dietary fiber and high in animal protein (especially beef), saturated and total fat as well as refined carbohydrates. Seventh-Day Adventists, who consume a vegetarian rather than a typical Western diet, exhibit lower death rates than the general population for cancers of the lung, mouth, and some other areas. Diet may not be the only factor or the contributing factor in cancer incidence; other factors also must be considered. The Seventh-Day Adventists, for example, also abstain from tobacco, alcohol, and coffee.

There are some studies that suggest a possible association between vegetarianism and a lower level of arterial disease. Compared to the general population, Seventh-Day Adventists exhibit lower incidence of atherosclerosis and later occurrence of the first heart attack. Western European populations subjected to World War I and II rationing demonstrated decreased incidence of circulatory diseases; their diets were essentially lacto vegetarian. And blood pressure does appear to be substantially *reduced* among vegetarians.

Pure vegetarians who consume no animal foods—compared to nonvegetarians and to those vegetarians who eat eggs and/or dairy products—generally exhibit the lowest serum cholesterol levels. They have lower low-density lipoprotein cholesterol (LDL) coupled with higher high-density lipoprotein cholesterol (HDL) levels. And they show lower levels of triglycerides.

Other dietary as well as nondiet-related risks also must be considered, however. For example, the vegetarian diet typically includes high fiber content from legumes. It is low in animal protein and includes a high level of complex

carbohydrates and phytosterols. In addition, diabetes mellitus, high blood pressure, obesity, and smoking may have been lower among the vegetarian groups studied.

CONCLUSION

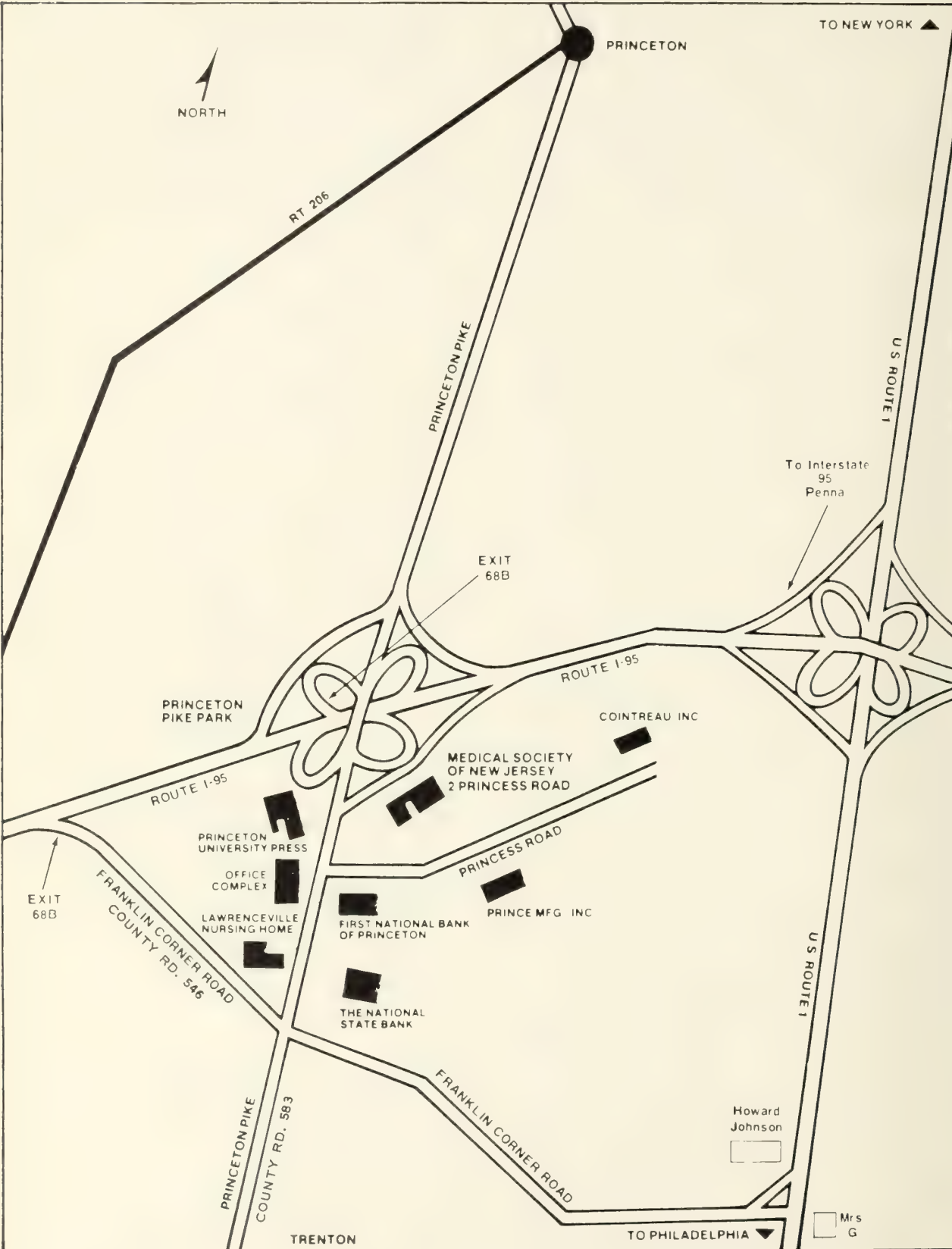
Health professionals, food scientists, and food communicators need to recognize that vegetarian practices today cover a wide range of eating styles with disparate and sometimes contradictory health effects. Some forms of vegetarianism do increase the risks of dietary deficiencies, malnutrition, and serious diseases or death. Other forms have obvious benefits as evidenced by those individuals and population groups who have practiced vegetarianism on a long-term basis and have demonstrated excellent health. The health risks of vegetarianism can be avoided and the benefits maximized when dietary planning is based on accurate, up-

to-date nutritional guidelines.

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Area Map—MSNJ Headquarters



Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Reference has been made several times previously in this space to the Federal Trade Commission. This body began looking at professions a few years ago, and it is showing more and more interest in "health care," particularly as it concerns physicians. You are familiar with FTC battles over physician advertising and relative value scales. Ethical principles which were established to protect the public from untrained and unskilled practitioners are currently under FTC scrutiny as "restraining trade".

A report by FTC staff was issued early this year, called "Medical Participation in Control of Blue Shield and Certain Other Open-panel Medical Prepayment Plans." The reasoning is: (1) cost of health care is rising; (2) physicians play a key role in health care; (3) most physicians are paid by insurance plans; (4) Blue Shield plans do the major part of physician payments; (5) physicians "control" Blue Shield plans; (6) such control keeps physician payments elevated, and keeps laymen from participating (these are FTC staff ideas, not mine). Medical societies should not "control," contribute, or appoint members to Blue Shield boards, peer review panels, fee committees, and so on. The providers of medical services should not be making the rules concerning payment for those services. A nonprofit medical society should not be involved with payment plans, because it's really fostering the interests of its for-profit physician members. As the FTC staff looked around, they noticed. Foundations for Medical Care (FMCs) and Individual Practice Associations (IPAs). Physicians and medical societies should not control these, either, says FTC staff, for the same reasons. Physician-generated criteria, utilization, peer review, and other parts of prepayment plans are suspect. Closed-panel HMOs are not a problem to FTC. Blue Cross plans do not appear to disturb them. Hospitals, being nonprofit, are not as troublesome

as the for-profit doctors. One of the advisers to the FTC suspects *anything* that physicians do in a group. If a group of physicians joined together and agreed to lower fees, that would be subject to antitrust review.

The staff report may or may not be acted on by the Commission by the time you read this. It could result in proposed rules appearing in the Federal Register, with eventual regulations being established. This is another item which deserves your attention, even if you hate Blue Shield. It says that doctors shouldn't be allowed to organize to do anything, from the AMA to your county society and hospital medical staff. I didn't realize that we all are so evil.

Surgeon General's Advisory*

Recent events have highlighted the importance of physicians and health professionals' giving greater attention to possible dangers of prescribing certain drugs to individuals who abuse alcohol. During the past several years there has been a major increase in this country in the medical and non-medical use of drugs. Concurrently, the wide use of alcohol by both men and women enhances the probability that alcohol and another drug will act simultaneously in many individuals, with serious and potentially fatal consequences. Indeed, alcohol use in combination with other drugs accounts for approximately 20 percent of the total number of accidental and suicidal deaths per year which are drug-related.

Concern over these trends prompts me to alert the medical profession to the special problems of prescribing certain drugs for patients who consume alcohol.

I wish to remind all physicians and health professionals that:

—many commonly prescribed drugs have altered therapeutic and/or adverse medical effects when taken with alcohol. These drugs include not only sedatives,

hypnotics, narcotics, antidepressants, and tranquilizers, but also certain anti-histamines, analgesics, anti-coagulants, and anti-infective agents.

—minor tranquilizers as well as other CNS depressants are used frequently by patients in combination with alcohol despite warnings to the contrary. This combined use may produce adverse medical consequences. Moreover, the resultant potentiation of CNS depression can impair performance of tasks requiring alertness—such as driving—increasing the likelihood of injury and even death. The combination itself can lead to death by accidental overdose or by suicide.

—the use of marijuana and other illicit psychoactive substances is widespread, and this use often occurs in combination with alcohol, or other licit psychoactive drugs.

Therefore, I urge all physicians and health professionals:

(1) routinely to document the history and scrutinize the pattern of alcohol consumption for individual patients to determine the possible relationship between presenting complaints and mixing drugs with alcohol;

(2) to be alert to the possible interaction of prescribed, over-the-counter, or illicit drugs—singly or in combination—with alcohol;

(3) to pay careful attention to the section in the package insert that deals with drug-alcohol interactions and consult the current medical literature and references for specific problems;

(4) to limit as much as is practical the quantity of drugs dispensed with any one prescription and monitor the patient with regular follow-ups for unexpected reactions to the medication;

(5) to consider, both in the choice of therapy and in the evaluation of the patient, the likelihood of the patient's adherence to your admonition (and that of the warning label on the prescription) against using alcohol while taking medication.

*Issued by Julius B. Richmond, M.D., Surgeon General of the Public Health Service, DHEW, Washington, DC 20201.

Guidelines and Objectives for Hospital Transfusion Committees*

The Revised Standards of the Joint Commission on Accreditation of Hospitals (JCAH) in accord with the statutory requirements of the Social Security Medicare Law, Title XVIII, Part A, Section 405.1028 requires that "facilities for procurement, safe-keeping, and transfusion of blood and blood products are readily available."¹ The JCAH further stipulates that all blood utilization be reviewed by a facility periodically to assure the adequacy, quality, and safety of blood product sources, transfusion practices, and effective utilization.²

In order to achieve these objectives and to comply with the Federal Food and Drug Administration (Bureau of Biologics) statutes mandating "safety, purity, and efficacy"³ of blood, components, and derivatives require a well-coordinated peer review body which must include the hospital blood bank director, those hospital services and departments which requisition and transfuse blood products, and the hospital administration's medical records' department. This body usually constitutes the transfusion committee of the hospital. The structure, composition, and objectives vary widely between individual hospitals depending on the size of the institution and the scope of health care facilities offered. Nevertheless, certain minimal requirements are necessary if this body is to fulfill the requirements of the JCAH and the Federal regulations. These guidelines and objectives suggest mechanisms which may be useful tools for hospitals of varying size and specialization in achieving compliance.

Definition: A hospital transfusion committee serves as a peer review body which functions to assure clinical quality control of the hospital's transfusion service, proper utilization of blood, blood components, and derivatives,⁴ and to disseminate current acceptable transfusion practices and policies to the hospital staff.⁵ A strong active committee is required to evaluate blood use, to formulate guidelines for safe and effective

transfusion therapy, and to enforce these recommendations.

Structure and Organization: The transfusion committee should be a free-standing body and not a subcommittee of another hospital committee. A hospital transfusion committee does not replace the surgical or medical morbidity conferences, but raises pertinent issues in blood utilization to be addressed in these respective committees. The transfusion committee also may assume leadership in promoting a donor replacement program and a hospital employee donor organization. This committee must meet at least quarterly, preferably monthly, or more frequently as necessity dictates. The committee should be structured so that a senior staff member of every major medical discipline is represented. Of particular importance are the following:

1. General surgery
2. Thoracic surgery
3. Clinical hematology
4. Pediatrics
5. Anesthesiology
6. Transplantation
7. Obstetrics/Gynecology
8. Radiology
9. Nursing and/or Phlebotomy service
10. Clinical pathology (Blood Bank Director and possibly the Supervisor)

If a committee member misses more than two consecutive meetings without good cause (out of town, pressing clinical duties, illness), he should be replaced. Senior residents of each medical discipline should be encouraged to attend and participate in the committee's activities. A member of the medical records' department is an invaluable adjunct to the committee as executive secretary. This person should be in charge of sending notices of meetings, responsible for having the appropriate charts available for review, taking minutes and distributing them to the committee members, preparing memoranda for the general hospital staff, and preparing letters of inquiry to individual staff members and house officers.

Objectives: The task of the transfusion committee has been defined "to review the records of all transfusion of blood and blood components to:

1. Assess transfusion reactions
2. Evaluate blood utilization
3. Make recommendations regarding specific improvements in transfusion services.⁶

This ideal is obviously impossible, however, statistics can be used economically to conserve the committee's time, improve the quality of transfusion poli-

cies and practices, and comply with the intent of the accrediting agencies' regulations. The following suggested agenda for the conduct of business for a transfusion committee should meet these requirements. Other outlines and approaches may be equally successful,⁷ depending on the scope and activities of the individual hospital's transfusion service.

1. Amendments and approval of the minutes of the last meeting: These may have been distributed to the members in advance.

2. **Old and new business** to establish policies and resolve grievances: In general, what is of current concern regarding the transfusion services and practices in the hospital should be reviewed. This may include a diversity of topics: review of blood requisition and transfusion forms to determine if the appropriate patient identification and clinical data have been included; assurance that authorized professionals are responsible for generating these requests; establishment of sound criteria for blood ordering policies; requirements for stats; guidelines for safe transfusion practices; and others. The resolution of these problems should result in policies for distribution to the hospital's staff.

3. Review of Blood Utilization:

(a) Percentage of outdated may indicate abuses, but this does not identify a particular problem or how to solve it.

(b) Percentage utilization, total number of units crossmatched/total number of units infused over a given period of time, is an invaluable statistical tool. This statistic can be obtained for the entire hospital, for a particular service, or for an individual physician. It quickly identifies the problem of overordering by a particular service or individual. By this method, the time that crossmatched units are held, the use of "Type and Hold"⁸ or multiple crossmatched units can be evaluated objectively for specific clinical needs and will improve utilization.

(c) The pattern of blood utilization can be determined by the total number of red blood cell units used divided by the total number of whole blood units used. This ratio indicates the use of whole blood and the use of red blood cells combined with discrete component therapy.^{6,7} This figure may vary among hospital departments depending on individual patient needs. However, an overall value greater than five is acceptable.

4. **Review and investigation of adverse transfusion reactions:**⁹ In documenting morbidity and mortality due to trans-

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fusion, firm criteria must be established for the classification of these reactions (i.e., hemolytic, delayed, allergic, febrile, and pyrogenic). Current regulations require a thorough clinical and laboratory investigation of all suspect hemolytic episodes. The extent of investigation of other adverse reactions is the responsibility of the blood bank director. The objective is to avoid unnecessary delay of transfusion to patients who have had minor transfusion complications.¹⁰ Nevertheless, all adverse reactions to transfusion of blood and blood products must be reviewed and categorized by the committee. In order that this may be done expeditiously, complete and accurate clinical data, laboratory investigation, and follow-up must be available. If it is not, then the chart must be considered incomplete until the clinician, nursing, or laboratory personnel furnishes the committee with the appropriate data so that a final disposition of that case can be made. Federal law, national accrediting agencies, and State law require that all cases of transfusion-associated jaundice and fatal transfusion reactions be reported to the supplier(s) providing the blood or blood components in that case.^{3,11,12}

5. Review of cases of unclear justification for type and/or amount of blood or blood component infused:¹³

(a) Single unit transfusions:

Many of these are legitimate, and proper latitude must be left to the attending physician's discretion as to the safe and proper treatment of his patient under any set clinical circumstances, i.e.:

- (1) pediatric patients
- (2) unstable vital signs during anesthesia
- (3) borderline anemia that requires minimal transfusion before a medical or surgical procedure can be safely performed. Documentation for these practices must be provided by uniform—
 - anesthesiology policies
 - radiology policies
 - other extenuating clinical circumstances
- (4) dialysis procedures
- (5) procedures involving extracorporeal circulatory support
- (6) transfusion of refractory,

chronically anemic patients

(7) underestimation of blood loss
 "Tonic" single-unit transfusion for whatever reason or transfusion to "promote good wound healing" is not acceptable.

(b) the amount and appropriate blood and component transfusion can be handled by the transfusion committee by several methods. A reasonable approach to this problem could be that during one meeting every three months, the following types of cases also could be perused briefly for quality of care:

- (1) multiples of three, under ten
- (2) multiples of four, under ten
- (3) over ten or total blood volume replacement with blood and blood components

6. Review of physical loss of blood resources in cases involving blood waste to determine whether the loss was unavoidable: The principal is to avoid the inherent risk of transfusion in certain cases, i.e., amelioration of a hemostatic condition which obviates the need for infusion of red blood cells, fresh frozen plasma, or platelet concentrates nearing expiration in order to avoid the inherent risk of transfusion in such instances even if the units may expire.⁷

7. Practical Considerations:

(a) It is questionable if the pathologist or director of laboratories who has the primary responsibility for the hospital's transfusion service should be chairman of the transfusion committee. The committee should serve both as a peer review of the transfusion service, as well as the hospital's staff members.

(b) The expeditious use of the committee members' time is well served by every member reviewing outstanding charts, summarizing cases briefly to the members, and providing his impressions to the committee for discussion and dispensation.

(c) Every member of the committee has the responsibility to correspond with his colleagues concerning unclear problems, or to refer problem cases to the appropriate department with full documentation. The chairman should coordinate these activities and include the correspondence and the response in the minutes of the meeting and in the

patient's chart.

(d) Each member of the committee must realize that he cannot impose his individual criteria for the practice of medicine on his colleagues. Guidance and continuing education should be one goal of the committee.

Summary: A transfusion committee which formulates significant transfusion procedures and practices should serve as a continuing peer review body for all aspects of blood usage. Its goal must be the assurance of quality, efficacy, safety, appropriate transfusion of blood, its products and derivatives. Continuing education of the hospital's professional personnel involved with transfusion must also be an inherent function of this committee.

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Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Douglas C. Wiseman, D.O., TH264 Pine Run, Blackwood 08012. College of Osteopathic Medicine, Kansas City (1974). Also general internal medicine. Board eligible (IM). Solo, group, partnership. Available.

Richard W. Huss, M.D., 555 Graham Rd., Fort Sam Houston, TX 78234. CMDNJ 1973. Subspecialty, immunology. Board certified. Group, partnership, solo. Available October 1979.

ANESTHESIOLOGY—June Hyung Rim, M.D., 11 Park Avenue, Apt. 3-0, Mt. Vernon, NY 10550. Seoul (Korea) 1973. Board eligible. Partnership, solo, group. Available.

Andrew Chih-Kang Cheng, M.D., 435 East 70th Street, Apt. 22-F, New York, NY 10021. Peking (China) 1962. Board eligible. Group, partnership, solo, administrative, research, or academic. Available.

Romeo Yangco Sembrano, M.B., Herbert J. Thomas Memorial Hospital, South Charleston, WV 25309. Santo Tomas (Philippines) 1962. Also general family practice. Board eligible. Solo, emergency room, partnership. Available.

Barry M. Baylis, M.D., 2130 Williamsbridge Road, Bronx, NY 10461. Wisconsin 1971. Board eligible. Partnership, group, solo. Available.

Raveendra Vithal Limaye, M.D., 335-D Third Avenue, Long Branch 07740. Baroda (India) 1972. Board eligible. Partnership, single or multispecialty group, institutional. Available.

Tulsiram Gowlikar, M.D., 2951 S. King Drive, Apt. 1009, Chicago, IL 60616. Gandhi (India) 1972. Board eligible. Solo, partnership, single-specialty group. Available.

Kiritkumar Sheth, M.D., 2851 S. King Drive, Apt. 1117, Chicago, IL 60616. Baroda (India) 1972. Special interest, family practice. Board eligible. Partnership, solo, public health. Available.

Hector R. Felbarg, M.D., 12 Kingsley Road, Huntington, New York 11743. Cordoba (Argentina) 1957. Board certified. Fee-for service. Available.

CARDIOLOGY—Lee M. Krause, D.O., 239 Brydon Road, Philadelphia, PA 19151. Phila. College of Osteopathy 1975. Also general internal medicine. Board eligible. Solo, group, partnership. Available July 1980.

Thomas J. Maley, M.D., 2525 South Boulevard, Idaho Falls, ID 83401. CMDNJ 1970. Also general internal medicine. Board certified (both). Group or partnership, prefer hospital-based. Available.

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Roger Neiss Zitrin, M.D., Micieli Place, Brooklyn, NY 11218. Rutgers, 1974. Also general internal medicine. Board eligible (IM). Solo, single or multi-specialty group. Available.

David H. White, M.D., 4119 Flint Hill, San Antonio, TX 78230. University of Texas 1972. Also general internal medicine. Board certified (IM). Institutional, single or multi-specialty group, partnership. Available.

Soma Narshiah Pulipati, M.D., 725 East Main Street, Kings Park, NY 11754. Osmania (India) 1971. Also general internal medicine. Board certified (IM). Solo, partnership, group. Available.

Vijay G. Mistry, M.D., 203 Fair Hill Towers, 12000 Fair Hill Road, Cleveland, OH 44120. T.N. Medical (India) 1973. Also general internal medicine. Board eligible (IM). Single or multi-specialty group, partnership. Available.

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Naresh K. Pruthi, M.D., 2600 44th Avenue, Apt. 1, San Francisco, CA 94116. All India Medical Institute 1973. Also general internal medicine. Board certified (IM). Solo, partnership, group. Available.

Nagorao V. Karhade, M.D., 1926 W. Harrison Street, Apt. 1804, Chicago, IL 60612. Aurangabad (India) 1970. Also general internal medicine. Board certified (IM). Board eligible. Solo, partnership, group. Available.

Dhirendra Mohan, M.D., 757 Main Street, Apt. 30, South Portland, ME 04106. King George (India) 1968. Also general internal medicine. Board certified (IM). Board eligible. Solo, industrial, emergency room. Available.

Brojesh C. Pakrashi, M.D. Medical Center, Morgantown, WV 26506. Medical College

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Lee Merrill Krause, D.O., 239 Brydon Road, Philadelphia, PA 19151. Phila. College of Osteopathic Medicine 1975. Also general internal medicine. Board eligible (IM). Solo, single or multi-specialty group, partnership. Available July 1980.

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David R. Benjamin, M.D., 2911 Stonecliffe Drive, Pittsburgh, PA 15146. Pittsburgh 1974. Also general internal medicine. Board certified (IM). Multi-specialty group, solo, partnership. Available.

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EMERGENCY MEDICINE—Jose S. Encanto, M.D., 89-06 135th Street, Apt. 7-J, Richmond Hill, NY 11418. Santo Tomas (Philippines) 1971. Special interest, clinical pathology. Board eligible (CP). Emergency room, institutional, multi-specialty group. Available.

ENDOCRINOLOGY—Ranjan P. Shah, M.D., 6120 Bellaire Boulevard, Apt. 812, Houston, TX 77081. University of Bombay (India) 1968. Also general internal medicine. Board eligible (IM). Any type practice. Available.

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FAMILY PRACTICE—John Schifferdecker, M.D., 52-08 69th Street, Maspeth, NY 11378. Mount Sinai, New York 1976. Board eligible. Partnership, single or multi-specialty group. Available.

Mark J. Decker, M.D., 115 Newbrook Lane, Bay Shore, NY 11706. Georgetown 1975. Board certified. Single specialty group, partnership, solo. Available.

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- Jaffer J. Khan, M.D., 638 22nd Street West, Bayonne. King Edward (Pakistan) 1969. Subspecialty, gastroenterology. Board eligible. Solo, multi-specialty group, single specialty group. Available.
- Mohammad S. Anwar, M.D., 194-01A 64th Circle, Apt. 1-C, Fresh Meadows, NY 11365. Liaquat Medical College (Pakistan) 1968. Board eligible. Solo, multi-specialty group, institutional. Available.
- Anthony E. Niescier, D.O., 3106 Aspen Circle, Norristown, PA 19401. Phila. College of Osteopathic Medicine 1975. Special interest, family medicine. Single-specialty group, partnership, multi-specialty group. Available.
- Chimanlal J. Patel, M.D., 89-06 135th Street, Apt. 6-A, Jamaica, NY 11418. Dr. V.M. Medical (India) 1971. Special interest, general medicine. Board eligible. Single or multi-specialty group, institutional. Available.
- Devi P. Misra, M.D., 7K University Terrace, Columbia, MO 65201. S.C.B. Medical School (India) 1969. Subspecialty, pulmonary disease. Board certified. Solo, multi-specialty group, institutional. Available.
- Silvestra Almirol, M.D., 234 Mass Avenue, Valley Cottage, Bronx, NY 10989. University of the East (Philippines) 1968. Subspecialty, neurology. Board eligible. Solo, multi-specialty group, institutional. Available.
- Ravi K. Malpam, M.D., 1165 Rt. 22, Apt. 22, North Plainfield 07061. Osmania (India) 1972. Subspecialty, pulmonary diseases. Board eligible. Institutional, solo, or multi-specialty group. Available.
- Pedro A. Rodriguez-Paiva, M.D., 2160 Matthews Ave., Apt. 6-M, Bronx, NY 10462. San Marcos (Peru) 1971. Board eligible. Single or multi-specialty group, institutional. Available.
- Mayank Y. Doshi, M.D., 520 Desplaines Ave., Apt. 303, Forest Park, IL 60130. Seth G.S. Medical (India) 1970. Subspecialty, endocrinology. Board certified. Partnership, single or multi-specialty group. Available.
- Muhammad G. R. Shaikh, M.D., 190-06A 69th Avenue, Flushing, NY 11365. Dacca (East Pakistan) 1964. Board eligible. Solo, partnership, single-specialty group. Available.
- Muhammad Tayyab, M.D., 2112 Starling

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Ave., Apt. 4-L, Bronx, NY 10462. King Edward (Pakistan) 1972. Board eligible. Solo, institutional, multi-specialty group. Available.

Josef H. Hertz, M.D., 840 E. 8th St., Brooklyn, NY 11230. Univ. of Bologna (Italy) 1974. Board eligible. Any type of practice. Available.

Chi-Pui Cheung, M.D., 2974 20 Lane, Apt. 3G, Brooklyn, NY 11214. National Med. (Taiwan) 1969. Subspecialties, hematology, oncology. Board certified. Solo. Available.

Kamran Hassidim, M.D., 4303 Caminito Del Zafiro, San Diego, CA 92121. Tehran (Iran) 1971. Subspecialties, hematology, oncology. Board eligible. Any type practice. Available.

Martin S. Lerman, M.D., 3307 Can-nongate Road, Apt. 10, Fairfax, VA 22031. Georgetown 1973. Board certified. Any type practice. Available.

Stuart H. Packer, M.D., 3406 Denise Street, Durham, NC 22704. SUNY-Downstate 1974. Special interest, hematology/oncology. Board certified. Group or partnership. Available July 1980.

Nanda K. S. Iyengar, M.D., 185 Ardsley Loop, Apt. 17-D, Brooklyn, New York 11239. Mysore (India) 1971. Special interest, cardiology. Any type practice. Available.

Abdul Majeed, M.D., 11-01 Kennedy Boulevard, North Bergen 07047. Dow (Pakistan) 1975. Board eligible. Institutional, solo, partnership. Available October 1979.

Miguel A. Maseda, M.D., 106 Fifth Avenue, Bradley Beach 07720. Madrid 1977. Single-specialty group, partnership, solo. Available July 1980.

Robert B. Liberman, M.D., 51 Harnden Avenue, Watertown, MA 02172. CMDNJ 1977. Single or multi-specialty group, partnership, research, institutional, solo. Available July 1980.

Sriram Sudarshan, M.D., 1100 Parsippany Boulevard, Apt. 263, Parsippany 07054. Gandhi Medical College (India) 1968. Subspecialty, cardiology. Board certified. Solo or partnership. Available.

James W. Baird, M.D., 1500 Locust Street, Apt. 3312, Philadelphia, PA 19102. Johns Hopkins 1968. Subspecialty, physical medicine and rehabilitation. Board certified. Multi-specialty group, partnership, solo. Available August 1980.

David A. Stein, M.D., 3811 Bluebonnet Boulevard, Houston, TX 77025. New York Medical 1975. Subspecialty, pulmonary diseases. Board certified. Partnership, institutional, multi-specialty group. Available October 1980.

NEPHROLOGY—Bassam M. Haddad, M.D. 725 Scotland Road, Orange 07050. Damascus, (Syria) 1972. Also general internal medicine. Board eligible. Single or multi-specialty group, solo. Available.

Rafael A. Javier, M.D., 1350 West Bethune, Apt. 1603, Detroit, MI 48202. Univ. of the Philippines 1972. Also general internal medicine. Board certified (IM). Single specialty group, partnership, solo. Available.

Jeevanandhan Rajaratnam, M.D., 1227 South Harlem Avenue, Apt. 306, Berwyn, IL 60402. Madurai (India) 1973. Also gen-

eral internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available.

Darius Arfaania, M.D., 1718 E. Broadway, Apt. D, Columbia, MO 65201. Pahlavi (Iran) 1973. Also general internal medicine. Board eligible (IM). Institutional, single or multi-specialty group. Available January 1980.

NEUROLOGY—Shashi A. Husain, M.D., 325 North 15th Street, Apt. 1012, Philadelphia, PA 19102. All India Institute 1968. Board eligible. Single or multi-specialty group, research, partnership. Available.

Gerald P. Durkan, M.D., 5852 Phillips Avenue, Pittsburgh, PA 15217. Jefferson 1975. Subspecialty, emergency medicine. Board eligible. Single or multi-specialty group, partnership. Available July 1980.

Leroy J. Pelicci, M.D., P.O. Box 1357, Hershey, PA 17033. Pennsylvania State Univ. 1975. Special interest, psychiatry. Partnership, single or multi-specialty group. Available July 1980.

Peter Greco, M.D., 2100 Foxhall Rd., Washington, D.C. 20007. Georgetown 1976. Board eligible. Group or partnership. Available July 1980.

Ahmad Y. Haffar, M.D., 1905 Faith Place, Gretna, LA 70053. Damascus (Syria). Solo, group, or partnership. Available October 1979.

NUCLEAR MEDICINE—David B. Plone, D.O., 533 Northlake Boulevard, North Palm Beach, FL 33408. Phila. Coll. of Osteopathy 1968. Subspecialty, radiology. Board certified. Single specialty group, partnership, institutional. Available July 1980.

OBSTETRICS/GYNECOLOGY—Jeng Y. Lin, M.D., 945 Harvest Lane, Indiana, PA 15701. China Medical College (Taiwan) 1968. Also general practice. Board eligible. Multi-specialty group, solo, or school health. Available.

Hooshang A. Amiri, M.D., 1100 Carson Drive, Huntingtown, MD 20639. Isfahan (Iran) 1965. Board certified. Solo. Available.

Jerome B. Goldstein, M.D., 6675 E. Heritage Place South Englewood, CO 80111. Texas 1976. Any type practice. Available July 1980.

Promila Mathur, M.D., 15 First Street, Apt. 8-D, Hackensack 07601. S.N. Medical (India) 1965. Board eligible. Institutional, single or multi-specialty group. Available.

Raymond Y. Fares, M.D., 1016 Lexington Avenue, New York, NY 10021. Alexandria (Egypt) 1962. Subspecialty, pathology. Board eligible. Any type practice. Available.

Chau-Kuang Lin, M.D., Route 224 R.D., Montour Falls, NY 14865. Kaohsiung (Taiwan) 1967. Board eligible. Single-specialty group, partnership, solo. Available.

Heinz O. Osterholzer, M.D., PSC 451, K.I. Sawyer AFB, Michigan 49843. Hahnemann 1968. Board eligible. Group or partnership. Available June 1980.

Richard J. Malafy, M.D., Box 31, Frankstown Road, Hollidaysburg, PA 16648. CMDNJ 1971. Board eligible. Group or partnership. Available.

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Jose S. Kua, M.D., 9503 Peartree Lane, Cypress, CA 90630. Santo Tomas (Philippines) 1971. Subspecialty, general practice. Board certified. Solo, partnership, single-specialty group. Available January 1980.

Yacov Tal, M.D., 2356 Mickle Avenue, Bronx, NY 10469. Tel Aviv (Israel) 1976. Partnership, single or multi-specialty group. Available July 1980.

Alejandro F. Aguilar, M.D., 602 Patterson Road, Bethel Park, PA 15102. San Agustin (Peru) 1969. Board eligible. Multi-specialty group, partnership, solo. Available January 1980.

Zuhair M. El Kalaadui, M.D., 100 Boteler St., Apt. 1106, Ottawa, Canada K1N 8Y1. Ain Shams (Egypt) 1972. Board eligible. Single or multi-specialty group, partnership. Available January 1980.

Michael T. Kicenuik, M.D., 49 Crescent Road, Livingston 07039. CMDNJ 1976. Group, partnership, solo, or industrial. Available July 1980.

Pablito S. Luz, M.D., 3506 Camellia Circle, Columbus, OH 39701. Far Eastern (Philippines) 1962. Board eligible. Partnership, single-specialty group, solo. Available March 1980.

ONCOLOGY—Ravi C. Khanna, M.D., 4962 Willoway Court East, Columbus, OH 43220. Amritsar (India) 1971. Also general internal medicine. Board certified (IM). Single-specialty group, partnership, solo. Available.

Pradeep S. Mahal, M.D., 12415 Newbrook Drive, Houston, TX 77072. All India 1974. Also general internal medicine. Board certified (IM). Solo, multi-specialty group, research. Available July 1980.

Enrico C. Sobong, M.D., 130 Gale Boulevard, Apt. 102, Melvindale, MI 48122. Also general internal medicine. Board certified (IM). Solo, partnership, single or multi-specialty group, institutional. Available.

Stanley Ostrow, M.D., 9 Wychwood Court, Baltimore, MD 21209. SUNY-Downstate 1974. Also general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available June 1980.

OPHTHALMOLOGY—Cary H. Freeman, M.D., 2309 West Broadway, Apt. 315, Columbia, MO 65201. Howard University 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Kenneth H. Zaslow, M.D., 20 Dykeman Road, Delmar, NY 12054. Albany 1973. Board certified. Single or multi-specialty group, partnership. Available.

Alan D. Gordon, M.D., 3230 Hayden Street, Sayre, PA 18840. CMDNJ 1974. Multi-specialty group, partnership, solo. Available July 1980.

Sam Katzurin, M.D., 258 Middle Neck Road, Great Neck, NY 11021. University of Bologna (Italy) 1973. Board eligible. Solo, partnership, multi-specialty group. Available.

Donald S. Gerber, M.D., 510 Second Avenue, Apt. 11-F, New York, NY 10016. Stanford 1975. Board eligible. Partnership, single-specialty group, solo. Available.

Wilma K. Brucker, M.D., 669-7 Willow Bend Drive, Clarkson, GA 30021. Med.

College of PA 1972. Board certified. Solo, multi-specialty group, ophthalmology group, or academic (not in large urban area). Available December 1979.

Ira Goodman, M.D., 643 West Barry, Chicago, IL 60657. Loyola 1974. Board certified. All types practice. Available November 1979.

Steven N. Cohen, M.D., 1355 Palos Verdes Drive, San Mateo, CA 94403. Cornell 1974. Board eligible. Solo, partnership, single-specialty group. Available.

Jerrold E. Ziperstein, M.D., 1900 Lyttons ville Road, Apt. 1314, Silver Spring, MD 20910. Montpellier (France) 1973. Board eligible. Partnership, single-specialty group, solo. Available October 1979.

Gregory I. Goldman, M.D., Texas Tech. University School of Medicine, Dept. of Ophthalmology, Lubbock, TX 79409. Far Eastern (Philippines) 1976. Solo, partnership, single or multi-specialty group. Available July 1980.

OTORHINOLARYNGOLOGY—Sultan F. Khan, M.D., 7 Seward Street, Dansville, NY 14437. King Edward (Pakistan) 1969. Board certified. Solo, partnership. Available October 1979.

Steven R. Chesnick, M.D., 50 Wyman St., Newton, MA 02168. Pittsburgh 1974. Board eligible. Single specialty group, partnership, multiple specialty group. Available.

Jeffrey Adelglass, M.D., 12 East 86th Street, New York, NY 10028. Board eligible. Group, partnership, solo. Available July 1980.

PATHOLOGY—A.H. Rao, M.D., 83-30 Viotor Ave., Apt. 201, Elmhurst, NY 11373. Gandhi (India) 1973. Board eligible. Partnership, institution, single specialty group. Available.

Marc G. Yagore, III, 6140 Edsall Rd., Alexandria, VA 22304. Univ. of Philippines 1972. Board certified. Institution, multi-specialty group, research, academic, administrative. Available.

Irwin J. Hollander, M.D., 2735 E. Country Club Rd., Philadelphia, PA 19131. Jefferson 1972. Board eligible. Institution, research, single specialty. Available.

Juan A. Suriel, M.D., 6 Dalecrest Court, Timonium, MD 21093. Univ. Santo Domingo 1971. Board eligible. Single or multi-specialty group, partnership, public health, research. Available.

Kong L. Tan, M.D., 338 High St., Perth Amboy, NJ 08861. Malang 1970. Board eligible. Partnership, institutional, multi-specialty group. Available.

Jose S. Encanto, M.D., 89-06 135th St., Richmond Hill, NY 11418. Univ. Santo Tomas (Philippines) 1971. Board eligible. Institution, multi-specialty group. Available.

N. Mirzabeigi, M.D., 603-B South Trenton Avenue, Pittsburgh, PA 15221. Teheran (Iran) 1967. Board certified (anatomical and clinical pathology). Associate or assistant. Available.

Singh C. Mohinder, MD., 470 Gale Boulevard, Melvindale, MI 48122. Maulana (India) 1970. Partnership, multi-specialty group, research. Available January 1980.

PEDIATRICS—S. R. Nanvati, M.D., 1945 Corlies Ave., Neptune, NJ 07753. B J Medical (India) 1970. Board eligible. Single specialty group, institution, solo. Available.

A. A. Vora, M.D., 63-43 Austin St., #1A, New York City 11374. All India University (India) 1962. Board eligible. Partnership, multi-specialty group, single specialty group, emergency room. Available.

Bernard Samtoy, M.D., 4634-B West Montague Ave., Charleston Hts., SC 29405. Montpellier (France) 1973. Board eligible. Single specialty group, partnership. Available.

R. K. Osei, M.D., 4000 Wilder Ave., Bronx, NY 10466. Ghana Med (Ghana) 1972. Institution, emergency room, single or multi-specialty group. Available.

R. B. Vasa, M.D., 321 East 13th St., New York City 10003. Baroda Faculty of Med (India) 1968. Board certified. Single specialty group, institution partnership. Available.

Yoon-Taek Chun, M.D., 1401 E. Hyde Park Blvd, Chicago 60615. Yonsei Univ (Korea) 1972. Board eligible. Single or multi-specialty group, partnership, solo. Available.

T. G. Thanjan, M.D., 3103 Fairfield Ave., Apt. 9K, New York City 10463. Med Col Kerala (India) 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Kusum Kumar, M.D., 125 Schroeder's Ave., Brooklyn, NY 11239. Gandhi Medical (India) 1962. Board eligible. Institution, multi-specialty group, partnership. Available.

D. J. Karnik, M.D., 26 Koster Blvd., Edison, NJ 08817. Grant Med (India) 1971. Board eligible. Partnership, single or multi-specialty group. Available.

N. R. Thotakura, M.D., 10 Overlook Rd., Apt. 6B, Summit, NJ 07901. Rangaraya Med (India) 1973. Board eligible. Multi-specialty group, single specialty group, partnership. Available.

B. W. Lee, M.D., 1160 Midland Ave., Apt. 8M, Bronxville, NY 10708. Yonsei Univ (Korea) 1973. Institution, single specialty group, partnership, multi-specialty, emergency room. Available.

S. A. Bharani, M.D., 21438 Dequindre St., Apt. 101, Warren, MI 48091. Baroda (India) 1976. Partnership, public health, solo, emergency room, single-specialty group. Available July 1980.

Eugene M. Shatz, M.D., Frankfurt Military Complex, Box 55, APO, NY 09710. Temple 1971. Board certified. Single or multi-specialty group, school health. Available July 1980.

Suryakumar Rajaram, M.D., 24 Wendy Lane, Charleston, SC 29407. Stanley Medical (India) 1969. Single specialty group, partnership, solo. Board eligible. Available January 1981.

Yousef Mardmomen, M.D., 113 Paulison Ave., Apt. K1, Passaic, NJ 07055. National Univ (Iran) 1972. Solo, multi-specialty group, academic. Available.

David I. Stolzenberg, M.D., 264-16 74th Avenue, Floral Park, NY 11004. Louvain (Belgium) 1976. Board eligible. Single or multi-specialty group, partnership. Available.

H. G. Tank, M.D., 111-28 66th St., Apt. 28, Forest Hills, NY 11375. MPS Med (India) 1974. Board eligible. Multi-specialty group, partnership, emergency room. Available.

M. Y. Najam, M.D., 4617 Shea Parkway, Corpus Christi, TX 78413. King Edward Med. (Pakistan) 1974. Board eligible. Partnership, Single specialty group, multi-specialty group. Available.

H. G. Levine, M.D., 2426 Lurting Ave., Bronx, NY 10469. Einstein, 1975. Board eligible. Single specialty, group, partnership. Available.

S. A. Rao, M.D., 950 49th St., Apt. 2G, Brooklyn, NY 11219. Bellary Med (India) 1974. Board eligible. Institutional, multi-specialty group, academic. Available.

Martin M. Fisher, M.D., Division of Adolescent Medicine, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042. Einstein 1975. Subspecialty, adolescent medicine. Board eligible. Group, partnership, institutional. Available July 1980.

Nelly A. Marklein, M.D., 88-34 Rutledge Avenue, Glendale, NY 11227. Santo Tomas (Philippines) 1963. Board certified. Multi-specialty group, solo, public health. Available January 1980.

Anju K. Khanijou, M.D., 260-14 74th Avenue, Glen Oaks, Queens, NY 11004. All-India 1973. Board eligible. Single or multi-specialty group, institutional. Available January 1980.

Bernardita T. Gabriel, M.D., 52-15 Seabury Street, Elmhurst, NY 11373. Santo Tomas (Philippines) 1972. Board eligible. Partnership, single or multi-specialty group. Available October 1979.

PHYSICAL MEDICINE/REHABILITATION—Sonthineni Govardhan, M.D., 80-15 41st Avenue, Apt. 340, Elmhurst, NY 11373. Guntur (India) 1972. Board eligible. Multi-specialty group, partnership, institutional. Available.

PSYCHIATRY—Leroy J. Pelicci, M.D., P.O. Box 1357, Hershey, PA 17033. Pennsylvania State 1975. Partnership, single or multi-specialty group. Available July 1980.

Datla S. Raju, M.D., P.O. Box 1453, Montheagen Avenue, Middletown, NY 10940. Rangaraya (India) 1970. Board eligible. Single or multi-specialty group, partnership. Available.

Willy Krauss, M.D., 2907 Townway, Danville, IL 61832. Hadasah (Israel) 1965. Board eligible. Single or multi-specialty group, partnership. Available.

Marc Rothman, M.D., Presidential Apts., Apt. C-822, City Line and Presidential Blvd., Philadelphia, PA 19131. SUNY-Upstate. Board eligible. Group, partnership, hospital. Available July 1980.

Pradeep Rattan, M.D., 1926 West Harrison, Apt. 1214, Chicago, IL 60612. Calcutta (India) 1972. Board eligible. Institutional, single-specialty group, partnership. Available.

PULMONARY DISEASES—Saroj Sehgal, M.D., 299 South Harrison Street, Apt. 3-C, East Orange 07018. Maulana Alad (India) 1972. Subspecialty, internal medicine. Board eligible (IM). Multi-specialty group, institutional, solo. Available.

RADIOLOGY—Anil G. Desai, M.D., 701 Red Bank Avenue, Apt. G-10, West Deptford 08096. Baroda (India) 1972. Special interests—diagnostic radiology and nuclear medicine. Board eligible. Partnership, single-specialty institution. Available.

R. Murty Krishnamsetty, M.D., 101 West 15th Street, Apt. 4-E North, New York, NY 10011. Banaras (India) 1971. Special interests—therapeutic radiology and nuclear medicine. Board certified. Research, institutional, multi-specialty group. Available.

Cyril Milunsky, M.D., 8 Old Colony Lane, Apt. 1, Arlington, MA 02174. Witwatersrand (South Africa) 1969. Board certified (diagnostic radiology). Single or multi-specialty group, partnership. Available.

Robert Baran, M.D., 31 Crest Lake Drive, Oak Ridge 07438. SUNY 1972. Board certified. Hospital or office-based group in northern New Jersey. Available.

RHEUMATOLOGY—Alan B. Fishman, M.D., 70 Centre Street, Apt. 2-D, Brookline, MA 02146. Subspecialty, internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available.

Zahid Husain, M.D., 60 Presidential Plaza, Apt. 1208, Syracuse, NY 13202. Dacca (Pakistan) 1972. Also general internal medicine. Board certified (IM). Partnership, solo, multi-specialty group. Available October 1980.

SURGERY, CARDIOVASCULAR—Cesar P. Veluz, M.D., 1200 North State Street, Box 1930, L.A. County USC Medical Center, Los Angeles, CA 90033. University of the Philippines 1971. Special interest, thoracic surgery. Board eligible (general surgery). Single or multi-specialty group, partnership. Available.

Naweed K. Majid, M.D., Box 85, USAF Hospital, USAF, APO NY 09220. King Edward (Pakistan) 1967. Special interest, thoracic surgery. Board certified (general surgery). Single or multi-specialty group, institutional. Available July 1980.

Peter Y. Chang, M.D., 3450 Wayne Avenue, Apt. 26-J, Bronx, NY 10467. Taipei (Taiwan) 1970. Special interest, general surgery. Board certified (general surgery). Any type practice. Available.

S. A. Paruk, M.D., 3131 Whitethorn Road, Cleveland Heights, OH 44118. Natal (South Africa) 1970. Special interest in thoracic and general surgery, transplantation. Board certified (general surg.) Group, academic, solo. Available July 1980.

Charles H. Antinori, M.D., 4400 Memorial Drive, Apt. 1019, Houston, TX 77007. Harvard 1973. Special interest, thoracic surgery. Board eligible (general surgery). Single-specialty group, solo, research. Available July 1980.

SURGERY, GENERAL—Jong Chun Moon, M.D., 420 Stockholm Street, Apt. B-6, Brooklyn, NY 11237. Kyungbuk (Korea) 1968. Board eligible. Partnership, solo, multi-specialty group. Available.

Richard A. Dietrich, M.D., 2205 Madison Road, Cincinnati, OH 45208. Cincinnati 1972. Board eligible. Single-specialty group, partnership, solo. Available.

Ibibama E. Afonya, M.D., 5 Fairview Terrace, East Green Bush, NY 12061. Ibadan (Nigeria) 1970. Board certified. Partnership, single or multi-specialty group. Available July 1980.

Kautilya A. Mehta, M.D., 6 Ashwood Court, Summit 07901. G. S. Medical College (India) 1967. Board eligible. Partnership, single specialty group, research. Available.

Luke J. Sheu, M.D., 2975 1/2 Northview Drive, Youngstown, OH 44504. Chung Shan (Taiwan) 1971. Special interest, emergency medicine. Board eligible. Partnership, multi-specialty group, emergency room. Available.

Ronald I. Lebman, M.D., 2300 Walnut St., Apt. 317, Philadelphia, PA 19103. Temple 1974. Board eligible. Partnership, single or multi-specialty group. Available.

Govindan Gandhi, M.D., 80 Guion Place, Apt. 12-P, New Rochelle, NY 10802. Thanjavur (India) 1973. Board eligible. Partnership, single specialty group, solo. Available.

Bose S. Mikkilineni, M.D., 555 Prospect Place, Brooklyn, NY 11238. Guntur (India) 1970. Special interest, abdominal surgery. Board eligible. Any type practice. Available.

Roshan H. Lalta-Singh, M.D., Roswell Park Memorial Institute, Buffalo, NY 14263. Kolhapur (India) 1968. Special interest, oncology. Board certified. Solo, partnership, multi-specialty group, institutional, public health. Available.

Young Nahm Lee, M.D., 1825 Parkside Drive, Apt. A-2, Park Ridge, IL 60068. Kyungpook (Korea) 1964. Special interest, general medicine. Board eligible. Partnership, multi-specialty group, solo. Available.

Kumar M. Nirmal, M.D., 220 Mount Vernon Place, Apt. 12-C, Newark 07106. K.G. Medical College (Lucknow, India) 1961. Board eligible. Single or multi-specialty group, solo. Available.

Joseph J. Rainone, M.D., 263-45 74th Avenue, Glen Oaks, NY 11004. SUNY-Upstate 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Thomas F. Street, Naval Regional Medical Center, FPO, San Francisco, CA 96652. George Washington 1972. Board certified. Multi-specialty group, partnership, research. Available.

Parvathareddy Ashok, M.D., 42-55 Colden Street, Apt. 9-E, Flushing, NY 11355. Andhra Medical (India) 1972. Board eligible. Partnership, multi-specialty group, solo. Available.

Michael F. Lane, M.D., 7901 Henry Avenue, Apt. C-411, Philadelphia, PA 19128. SUNY-Downstate 1971. Board eligible. Partnership, single or multi-specialty group. Available.

Rajesh Khanijou, M.D., 260-14 74th Avenue, Glen Oaks, Queens, NY 11004. All-India 1973. Board eligible. Single or multi-specialty group, partnership, institutional. Available January 1980.

Raduf B. Korkor, M.D., 7600 Kirby Drive, Apt. 1313, Houston, TX 77030. Damascus

(Syria) 1973. Special interest, colon and rectal surgery. Board eligible (general surgery). Single or multi-specialty group, partnership, solo. Available.

SURGERY, HEAD/NECK—Joseph B. Jacobs, M.D., 3241 Woodbine Street, Los Angeles, CA 90064. Einstein 1974. Sub-specialty, otorhinolaryngology. Board certified (otorhinolaryngology). Partnership, research, multi-specialty group. Available.

SURGERY, ORTHOPEDIC—James K. Koh, M.D., U.S. Naval Reg. Medical Center, FPO, San Francisco, CA 96652. University of Pennsylvania 1972. Board certified. Single or multi-specialty group, partnership. Available.

Nicholas Cappello, M.D., 663 Young Road, Erie, PA 16509. Creighton 1975. Board eligible. Single or multi-specialty group, partnership, research, public health, emergency room. Available July 1980.

Victor Tseng, M.D., 1019 Everett Avenue, Apt. 3, Louisville, KY 40204. SUNY-Downstate 1970. Special interest, hand surgery. Board eligible. Single-specialty group, partnership, solo. Available November 1979.

Kaushal K. P. Sinha, M.D., 3513 Cairnbrook Drive, Columbia, SC 29210. Prince of Wales (India) 1966. Board eligible. Solo, partnership, single-specialty group. Available.

Stephen L. Brenner, M.D., 350 East 17th Street, Apt. 17-A, New York, NY 10003. Guadalajara 1974. Single or multi-specialty group, partnership. Available July 1980.

SURGERY, UROLOGICAL—Steven H. Paletsky, M.D., 126-C Remington Avenue, Syracuse, NY 13210. South Carolina 1973. Board eligible. Partnership, solo, single-specialty group. Available.

John Thomas Sommer, M.D., 5325 N. Lakewood Avenue, Chicago, IL 60640. University of Virginia 1972. Partnership, research, single-specialty group. Available July 1980.

Ran Abraham, M.D., 420 East 80th Street, Apt. 8-I, New York, NY 10021. Lausanne 1974. Board eligible. Partnership, single-specialty group, solo. Available.

David J. Caro, M.D., 300 East 34th Street, New York, NY 10016. Cornell 1973. Board eligible. Partnership, single or multi-specialty group. Available.

Vincent J. Lanteri, M.D., 689 Passaic Avenue, Clifton 07012. Guadalajara 1974. Partnership, single-specialty group, solo. Available July 1980.

Fredy E. Delacruz, M.D., Box O, Balboa Heights, Balboa, Canal Zone. Guadalajara 1972. Board eligible. Partnership, solo, institutional, multi- or single-specialty group. Available November 1979.

Philip L. Miller, M.D., 333 East 30th Street, Apt. 18-B, New York, NY 10016. Chicago 1973. Partnership, single or multi-specialty group. Available July 1980.

Vodur C. Reddy, M.D., 1571 Main Street, Apt. 26, West Warwick, RI 02893. Guntur (India) 1961. Partnership, single or multi-specialty group. Available July 1980.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

As CMDNJ begins a new school year, a new sense of pride is instilled in the students, faculty members, employees, and administrators on all of the College's campuses. The pride is in the full accreditation recently awarded CMDNJ by the Middle States Association of Colleges and Schools.

The Association's Commission on Higher Education granted the College a five-year accreditation—the maximum granted on initial application—and described the College's programs with high praise. The Commission notified us of this good news following a meeting of the Association's board on June 21-23.

Besides the pride in the recognition of CMDNJ as a fully accredited educational institution, the Middle States accreditation is valuable to us because it will afford the College great benefit in requests for funding for special programs, it will afford significant credibility in the granting of degrees, and it will strengthen the College in joint degree programs with other institutions.

Equally important is that the accreditation reaffirms our conviction that the directions we've chosen have been the right ones, for the Association's report indicated that CMDNJ's three-fold mission of health education, service, and research is one with special meaning at CMDNJ. The report also characterized CMDNJ as "a young, vital institution which has made extraordinary progress in providing the State of New Jersey with a balanced and comprehensive resource for training physicians, dentists, allied health professionals, and scholars in medical research."

It is significant that CMDNJ received this positive evaluation on its first attempt for accreditation from the Middle States Association, an independent, regional accrediting body whose members include nearly 500 colleges and universities in five states plus the District of Columbia, Puerto Rico, Canal Zone, and the U.S. Virgin Islands.

Each of CMDNJ's schools has been fully accredited by its relevant professional accrediting body, but this represents the first college-wide accreditation. CMDNJ's present status will be reviewed again in five years.

The process toward accreditation was begun three years ago, when the College, as a new institution, was admitted to candidacy for membership in the As-

sociation. Over the last two years, the College undertook an institution-wide self-study, which allowed us to step outside of the day-to-day pressures and to take a fresh look at our institution's strengths as well as its weaknesses. The self-study was followed by a site visit last May by a ten-member evaluation team composed of distinguished educators, whose report led to the accreditation.

While the report gave high marks to all of the units of CMDNJ, including its schools, hospitals, libraries, and administration, it raised four minor questions to which CMDNJ will respond by April, 1981. The areas identified, which are among the priority issues already under consideration by CMDNJ, include:

1. The feasibility of continuing to offer basic sciences for the students of the CMDNJ-New Jersey School of Osteopathic Medicine at the College's Piscataway campus, while clinical programs are offered in Camden.

2. Provisions of better facilities to house the CMDNJ-School of Allied Health Professions in Newark.

3. Progress in upgrading the research productivity in the Newark and Camden components.

4. Clearer definition of the roles assigned to the President of the College, its Board of Trustees, and the State Board of Higher Education.

The report, however, praised the "candor with which yet-to-be-solved problems are surfaced and forthrightly acknowledged" by CMDNJ, and hailed its "signal success" in resolving many of its difficulties to date. The report found "a demonstrated capacity for ingenious adaptation and accommodation of the various components of CMDNJ" which, it said, "augurs well" for the solution of such problems.

"In a young institution like CMDNJ," the report states, "developing as it has in unique and often troubled circumstances, it often has been necessary to break with traditional methods and thinking, and to experiment with new means of meeting its particular needs."

It is gratifying to all within the CMDNJ family to see the efforts of the College's faculty, staff, administration and trustees, and those of the State of New Jersey, through its Board of Higher Education, approved by an independent agency such as the Middle States Association. It was certainly reassuring to hear an impartial panel reaffirm our own hopes for a "bright future as a distinguished center for education, research and public service."

1979-1980

Committees and Councils

Standing Committees

Advisory to Women's Auxiliary

Frederick W. Durham, M.D., <i>Chairman</i>	
(1980)	Haddonfield
Ralph J. Fioretti, M.D., <i>Vice-Chairman</i>	
(1980)	Rochelle Park
Julius Baber, M.D. (1981)	Bayonne
James E. Brennan, M.D. (1982)	Cherry Hill
J. James Pegues, M.D. (1981)	Mount Holly
Frank R. Romano, M.D. (1982)	Dunellen

Annual Meeting

Ralph J. Fioretti, M.D., <i>Chairman</i>	
(1981)	Rochelle Park
Francis X. Keeley, M.D., <i>Vice-Chairman</i>	
(1980)	Haddonfield
Joseph P. Cillo, M.D. (1982)	Cranford
Arthur C. Dietrick, M.D. (1981)	Mount Holly
Carl A. Restivo, M.D. (1982)	Jersey City
James H. Spillane, M.D., (1980)	Phillipsburg
Arthur Bernstein, M.D. (Secretary),	
<i>Ex-officio</i>	East Orange
H. Irving Dunn, M.D., <i>Consultant</i>	Mantoloking
Charles S. Kruger, M.D., <i>Consultant</i>	Mount Holly

Scientific Program (Sections)

Allergy

Richard J. Bukosky, M.D., <i>Chairman</i>	Linden
Martin Green, M.D., <i>Secretary</i>	Margate

Anesthesiology

Tai-Hsiung Pan, M.D., <i>Chairman</i>	Hackensack
Harvey J. Hatchfield, M.D., <i>Secretary</i>	Hackensack

Cardiovascular Diseases

Jayant Patel, M.D., <i>Chairman</i>	Wood-Ridge
Daniel J. Goodman, M.D., <i>Secretary</i>	Hackensack

Chest Diseases

Arnold I. Miles, M.D., <i>Chairman</i>	Wayne
Lee Reichman, M.D., <i>Secretary</i>	Newark

Clinical Pathology

John C. Baylis, M.D., <i>Chairman</i>	Berlin
Lawrence C. Sylvia, M.D., <i>Secretary</i>	Long Branch

Dermatology

Fred Haberman, M.D., <i>Chairman</i>	Hackensack
Robert Schneider, M.D., <i>Secretary</i>	Somerville

Emergency Medicine

Robert Holliday, D.O., <i>Chairman</i>	Edison
John P. Salvo, M.D., <i>Secretary</i>	Medford

Family Practice

Paul J.V. Rizzuto, M.D., <i>Chairman</i>	Orange
Salvatore J. Angelo, M.D., <i>Secretary</i>	Toms River

Gastroenterology and Proctology

Raymond F. Crystal, M.D., <i>Chairman</i>	Morristown
Michael A. Samach, M.D., <i>Secretary</i>	Denville

Medicine

Fong Wei, M.D., <i>Chairman</i>	Princeton
John S. Sierocki, M.D., <i>Secretary</i>	Princeton

Neurosurgery and Neurology

Robert Fisher, M.D., <i>Chairman</i>	Piscataway
Pamela S. Chavis, M.D., <i>Secretary</i>	Newark

Nuclear Medicine

David I. Kingsley, M.D., <i>Chairman</i>	Edison
Martin I. Parker, M.D., <i>Secretary</i>	Edison

Obstetrics and Gynecology

John D. Franzoni, M.D., <i>Chairman</i>	Trenton
James P. Thompson, M.D., <i>Secretary</i>	Paterson

Oncology

Erwin Tepper, M.D., <i>Chairman</i>	Union
Donald K. Brief, M.D., <i>Secretary</i>	Union

Ophthalmology

Harry T. Friebe, M.D., <i>Chairman</i>	Medford
Mark L. Engel, M.D., <i>Secretary</i>	Matawan

Orthopedic Surgery

Ralph J. Cavalier, Jr., M.D., <i>Chairman</i>	Atlantic City
Edmund R. Kappy, M.D., <i>Secretary</i>	Red Bank

Otolaryngology

James H. Spillane, M.D., <i>Chairman</i>	Phillipsburg
Lindsay L. Pratt, M.D., <i>Secretary</i>	Camden

Pediatrics

Stanley Karp, M.D., <i>Chairman</i>	Cinnaminson
Stephen F. Wang, M.D., <i>Secretary</i>	Morristown

Physical Medicine and Rehabilitation

Melvin J. Goldberg, M.D., <i>Chairman</i>	Clifton
Secretary to be appointed	

Plastic and Reconstructive Surgery

Richard B. Bloomenstein, M.D., <i>Chairman</i>	Englewood
Carl Quillen, M.D., <i>Secretary</i>	East Orange

Psychiatry

Lawrence B. Erlich, M.D., <i>Secretary</i>	Haddonfield
George Wilson, M.D., <i>Secretary</i>	Belle Mead

Radiology

Herman M. Robinson, M.D., <i>Chairman</i>	Orange
Secretary to be appointed	

Rheumatism

William E. Ryan, M.D., <i>Chairman</i>	Pennington
R. Michael Roberts, M.D., <i>Secretary</i>	Princeton

Surgery

Bruce J. Brener, M.D., <i>Chairman</i>	Millburn
Cyril S. Arvanitis, M.D., <i>Secretary</i>	Long Branch

Urology

Louis I. Keeler, M.D., <i>Chairman</i>	Collingswood
Secretary to be appointed	

Credentials

Arthur Bernstein, M.D., <i>Chairman</i>	
(Secretary), <i>Ex-Officio</i>	East Orange
Roger C. Laauwe, M.D., <i>Vice-Chairman</i>	
(1980)	Wayne
William A. Allgair, M.D., (1982)	South River
Samuel C. Ingraham, II, M.D. (1981)	Ocean City
Thomas E. Mattingly, Jr., M.D. (1982)	Mount Holly
Marcel A. Mersch, M.D. (1980)	Hackettstown
Lawrence B. Owen, M.D. (1981)	Woodstown

Finance and Budget

Richard E. Lang, M.D., <i>Chairman</i> (1981)	Passaic
William Greifinger, M.D., <i>Vice-Chairman</i>	
(1982)	Belleville
Harry M. Carnes, M.D. (1981)	Audubon
Palma E. Formica, M.D. (1982)	Old Bridge
Charles S. Krueger, M.D. (1980)	Mount Holly
James S. Todd, M.D. (1980)	Ridgewood
Rudolph C. Gering, M.D. (Treasurer),	
<i>Ex-Officio</i>	Pennington

Medical Defense and Insurance

Michael J. Doyle, M.D., <i>Chairman</i>	
(1982)	Neptune
Frank J. Malta, M.D., <i>Vice-Chairman</i>	
(1980)	Toms River
Irving P. Borsher, M.D. (1980)	Newark
Paul J. Hirsch, M.D. (1981)	Bridgewater
Stanley Karp, M.D. (1982)	Cinnaminson
E. Arthur Kratzman, M.D. (1981)	Plainfield
William G. Kuhn, Jr., M.D. (1979)	New Brunswick
Arthur Bernstein, M.D. (Secretary),	
<i>Ex-Officio</i>	East Orange
John J. Crosby, Jr., M.D., <i>Consultant</i>	Jersey City
William J. D'Elia, M.D., <i>Consultant</i>	Spring Lake
Ralph J. Fioretti, M.D., <i>Consultant</i>	Rochelle Park
John D. Franzoni, M.D., <i>Consultant</i>	Trenton
Ernest C. Hillman, Jr., M.D., <i>Consultant</i>	Glen Ridge
Paul J. Kreutz, M.D., <i>Consultant</i>	Elizabeth
Henry Liss, M.D., <i>Consultant</i>	Chatham
Daniel J. O'Regan, M.D., <i>Consultant</i>	Lawrenceville
Jesse Schulman, M.D., <i>Consultant</i>	Lakewood

Medical Education

Arthur Bernstein, M.D., <i>Chairman</i> (1980)	East Orange
Edwin W. Messey, M.D., <i>Vice-Chairman</i>	
(1981)	Willingboro
Alfred A. Alessi, M.D. (1980)	Hackensack
Robert W. Parvin, M.D. (1982)	Mount Holly
William Pomerantz, M.D. (1982)	Randolph
Sidney Woltz, M.D. (1981)	Union City
Steven Arvan, M.D., <i>Consultant</i>	Atlantic City
Paul J. Hirsch, M.D., <i>Consultant</i>	Bridgewater
William F. Minogue, M.D., <i>Consultant</i>	Summit
Robert S. Rigolosi, M.D., <i>Consultant</i>	Paramus
James A. Rogers, M.D., <i>Consultant</i>	Paterson
John S. Thompson, M.D., <i>Consultant</i>	Morristown
William S. Vaun, M.D., <i>Consultant</i>	Long Branch

Medical Student Loan Fund

Palma E. Formica, M.D., <i>Chairman</i>	
(1981)	Old Bridge
James P. Thompson, M.D., <i>Vice-Chairman</i>	
(1980)	Upper Montclair
Antonio P. Battaglia, M.D. (1982)	Gibbstown
William R. Muir, M.D. (1980)	Mount Holly
Pasquale A. Ruggieri, M.D. (1982)	Vineland

Publication

John F. Marshall, M.D., <i>Chairman</i>	
(1981)	Trenton
Julio del Castillo, M.D. (1980)	Trenton
Paul J. Hirsch, M.D. (1982)	Bridgewater
Augustus L. Baker, Jr., M.D. (President-Elect),	
<i>Ex-Officio</i>	Hackensack
Arthur Bernstein, M.D. (Secretary),	
<i>Ex-Officio</i>	East Orange
Arthur Krosnick, M.D. (Editor), <i>Ex-Officio</i>	Trenton
Daniel B. Roth, M.D., <i>Consultant</i>	Teaneck

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., <i>Chairman</i>	
(1981)	Morristown
Daniel J. O'Regan, M.D., <i>Vice-Chairman</i>	
(1982)	Jersey City
Lawrence B. Owen, M.D. (1980)	Salem
Carl A. Restivo, M.D. (1981)	Jersey City
Arthur G. Sullivan, Jr., M.D. (1980)	Bound Brook
Charles O. Tyler, M.D. (1982)	Camden
Arthur Bernstein, M.D. (Secretary),	
<i>Ex-Officio</i>	East Orange
William J. D'Elia, M.D., <i>Consultant</i>	Spring Lake
John S. Madara, M.D., <i>Consultant</i>	Salem
Henry J. Mineur, M.D., <i>Consultant</i>	Cranford
Charles I. Nadel, M.D., <i>Consultant</i>	Irvington

Administrative Councils

Legislation

Daniel J. O'Regan, M.D., <i>Chairman</i> (1980)	Jersey City
John D. Franzoni, M.D., <i>Vice-Chairman</i>	
(1982)	Trenton
Peter A. Beaugard, M.D. (1981)	Teaneck
Donald P. Burt, M.D. (1981)	Morristown
John J. Crosby, Jr., M.D. (1982)	Jersey City
William J. D'Elia, M.D. (1980)	Spring Lake
Leon A. Fraser, M.D. (1982)	Trenton
S. Stuart Mally, M.D. (1982)	Atlantic City
Samuel B. Pole, III, M.D. (1981)	Bridgeton
Irving P. Ratner, M.D. (1980)	Willingboro
Bernard A. Rineberg, M.D. (1981)	New Brunswick
John R. Tobey, M.D. (1980)	Newark
James S. Todd, M.D. (Chairman, Board of Trustees), <i>Ex Officio</i>	Ridgewood

Medical Services

Victor H. Boogdanian, M.D., <i>Chairman</i>	
(1980)	New Brunswick
John S. Madara, M.D., <i>Vice-Chairman</i> (1980)	Salem
John R. Doyle, M.D. (1982)	Hackensack
Armando F. Goracci, M.D. (1981)	Woodbury
Gustav L. Ibranyi, M.D. (1981)	Newark
Eugene H. Kain, M.D. (1982)	Pennsauken
Robert S. Rigolosi, M.D. (1982)	Paramus
William E. Ryan, M.D. (1982)	Trenton
Richard H. Sharrett, M.D. (1980)	Plainfield
Charles O. Tyler, M.D. (1980)	Cherry Hill
Edwin S. Wilson, M.D. (1981)	Moorestown
Frank A. Wolf, M.D. (1981)	Phillipsburg
Augustus L. Baker, Jr., M.D. (President-Elect),	
<i>Ex-Officio</i>	Dover
Matthew E. Boylan, M.D.,	
<i>Consultant</i>	Avon-By-The-Sea
Karl T. Franzoni, M.D., <i>Consultant</i>	Trenton
Frank M. Galio, M.D., <i>Consultant</i>	Bloomfield
Charles S. Krueger, M.D., <i>Consultant</i>	Mount Holly
Joseph A. Lepree, M.D., <i>Consultant</i>	Elizabeth
Nicholas E. Marchione, M.D., <i>Consultant</i>	Vineland
James A. Rogers, M.D., <i>Consultant</i>	Paterson

Mental Health

Harry H. Brunt, Jr., M.D., <i>Chairman</i>	
(1980)	Neptune
Farrell R. Crouse, M.D., <i>Vice-Chairman</i> (1982)	Woodstown
William H. Bristow, Jr., M.D. (1982)	Ridgewood
Joseph P. Cillo, M.D. (1981)	Cranford
Alvin Friedland, M.D. (1980)	Livingston
Raymond H. Gehl, M.D. (1982)	West Orange
Joseph J. Kline, M.D. (1981)	Trenton
Alan Kulick, M.D. (1982)	Vineland
Gerald H. Rozan, M.D. (1980)	Wayne
Nancy S. Sibert, M.D. (1981)	West Deptford
G.L. Triebenbacher, M.D. (1982)	Beach Haven
B. Ralph Wayman, M.D. (1981)	Morrisville, Pa.
Charles S. Krueger, M.D. (Immediate Past-President), <i>Ex-Officio</i>	Mt. Holly
Robert S. Albahary, M.D., <i>Consultant</i>	Somerset
Thomas R. Houseknecht, M.D., <i>Consultant</i>	Moorestown
Arnold M. Kallen, M.D., <i>Consultant</i>	Piscataway
Martin H. Weinberg, M.D., <i>Consultant</i>	Trenton

Public Health

Peter A. Gross, M.D., <i>Chairman</i>	
(1982)	Hackensack
Edward M. Coe, M.D., <i>Vice-Chairman</i>	
(1980)	Cranford
Thomas E. Desmond, M.D. (1982)	Edison
Mary DiMedio, M.D. (1981)	Woodstown
Albert Ehrlich, M.D. (1982)	Fort Lee
Enrico C. Funaro, M.D. (1982)	Morristown
Samuel C. Ingraham, II, M.D. (1981)	Ocean City

Patrick J. McGovern, M.D. (1981)	Jersey City
Charles J. Moloney, M.D. (1981)	Moorestown
Watson E. Neiman, M.D. (1980)	Cinnaminson
Bernard A. Rineberg (1980)	New Brunswick
Robert E. Verdon (1980)	Cliffside Park
Armando F. Goracci, M.D. (First Vice-President), <i>Ex-Officio</i>	Woodbury
Ronald Altman, M.D., <i>Consultant</i>	Trenton
William J. Dougherty, M.D., <i>Consultant</i>	Trenton

Public Relations

Frank Y. Watson, M.D., <i>Chairman</i> (1980)	Montclair
Frank J. Malta, M.D., <i>Vice-Chairman</i> (1980)	Toms River
Milton R. Bronstein, M.D. (1982)	Edison
Ralph J. Fioretti, M.D. (1981)	Rochelle Park
Andrew G. Hudacek, M.D. (1981)	Morristown
Alexander D. Kovacs, M.D. (1982)	Scotch Plains
Edwin W. Messey, M.D. (1979)	Willingboro
Gastone A. Milano, M.D. (1981)	Atlantic City
James A. Rogers, M.D. (1981)	Paterson
Victor M. Ruby, M.D. (1982)	Atlantic City
Jesse Schulman, M.D. (1980)	Lakewood
B. Ralph Wayman, Jr., M.D. (1980)	Morrisville, Pa.
Howard D. Slobodien, M.D. (2nd Vice-President), <i>Ex-Officio</i>	Perth Amboy
Louis G. Bosco, M.D., <i>Consultant</i>	Clifton

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

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Mathilda R. Vaschak, M.D., <i>Vice-Chairman</i>	North Plainfield
John W. Holdcraft, M.D.	Woodbury
Andrew G. Hudacek, M.D.	Morristown
M. Noel Jennings, M.D.	Holmdel
Daniel J. O'Regan, M.D.	Jersey City
Ralph A. Young, M.D.	Maplewood
George A. Zazanis, M.D.	Chatham
Joshua N. Zimskind, M.D.	Trenton
Elmer J. Elias, M.D., <i>Consultant</i>	Trenton
William E. Neeld, M.D., <i>Consultant</i>	Deepwater

Special Committees to Council on Public Health

Cancer Control

Roy T. Forsberg, M.D., <i>Chairman</i>	Westfield
Bernard J. Koven, M.D., <i>Vice-Chairman</i>	Englewood
Sherman Garrison, M.D.	Bridgeton
Warren H. Knauer, M.D.	Hillside
Charles S. Krueger, M.D.	Mount Holly
Albert A. Pineda, M.D.	Clifton
Benjamin F. Rush, Jr., M.D.	Newark
Elissa J. Santoro, M.D.	Irvington
Eva B. Stahl, M.D.	New Brunswick

Child Health

Glenn P. Lambert, M.D., <i>Chairman</i>	Flemington
Anthony Brickman, M.D.	Trenton
John R. Doyle, M.D.	Hackensack
William J. Farley, M.D.	Brielle
Douglas Ford, M.D.	East Orange
Robert E. Jennings, M.D.	South Orange
Roger B. Kane, M.D.	Dover
John J. LaMar, Jr., M.D.	Salem

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., <i>Chairman</i>	Trenton
Howard S. Farmer, M.D.	Princeton
Stephen Freifeld, M.D.	East Orange
Patrick Houston, M.D.	Cherry Hill
Rowan C. Pearce, Jr., M.D.	Haddonfield
Lindsay L. Pratt, M.D.	Camden
Robert Stern, M.D.	Mount Holly
Raymond B. Strauss, M.D.	Englewood
Albert F. Moriconi, M.D., <i>Consultant</i>	Trenton

Conservation of Vision

Jordan D. Burke, M.D., <i>Chairman</i>	Summit
Alfonse A. Cinotti, M.D.	Jersey City
Ralph L. Dicker, M.D.	Dover
Samuel Diskan, M.D.	Atlantic City
Harry T. Friebe, M.D.	Marlton
Oram R. Kline, M.D.	Camden
Samuel B. Pole, III, M.D.	Bridgeton
Ralph A. Skowron, M.D.	Cherry Hill
Harvey P. Yeager, M.D., <i>Consultant</i> , President, NJ Academy of Ophthalmology and Otolaryngology	Millburn
Vincent B. Pica, M.D., <i>Consultant</i> , President-Elect, NJ Academy of Ophthalmology and Otolaryngology	Trenton

Environmental Health

Philip J. G. Quigley, M.D., <i>Chairman</i>	Elizabeth
Seymour Charles, M.D.	Irvington
Stanley R. Lane, M.D.	Moorestown
Richard H. Musnug, M.D.	Medford Lakes
E. Spencer Paisley, M.D.	Haddon Heights
Frank L. Rosen, M.D.	Maplewood
William I. Weiss, M.D.	Livingston
Meyer T. Weissman, M.D.	Elizabeth
Morris Joselow, Ph.D., <i>Consultant</i>	Newark

Maternal and Child Care

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Pascal L. Federici, M.D.	Long Branch
Caterina A. Gregori, M.D.	Livingston
Gerard F. Hansen, M.D.	Hackensack
John T. Harrigan, M.D.	Westfield
Michael S. Kreitzer, M.D.	Westfield
Edwin W. Messey, M.D.	Willingboro
Thomas A. Noone, M.D.	Haddonfield
Nicholas J. Salerno, M.D.	Marlton
Thomas R.C. Sisson, M.D.	Perth Amboy
James P. Thompson, M.D.	Paterson
Felix H. Vann, M.D.	Tenafly
Margaret Gregory, M.D., <i>Consultant</i>	Trenton
Leah Z. Ziskin, M.D., <i>Consultant</i>	Trenton

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Werner J. Hollendonner, M.D.	Trenton
Lawrence J. Mazzei, M.D.	Hackettstown
A. Gerard Peters, M.D.	Paterson

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 Philip Boyer, M.D. Pennsville
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 Edward T. Carden, M.D. Moorestown
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 Ervin Moss, M.D. Verona
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 Union County Medical Society Mountainside
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Consultant Roseland

Blue Shield and Utilization Review

July 13, 1979

Dear Dr. Krosnick:

My letter is directed to you and the publication committee about the ad in *The Journal* of the Medical Society of New Jersey. The specific ad which I am talking about is present on page 487 (76:487, July 1979), submitted by the Blue Shield of New Jersey.

The reason I take issue with this is because the large bold print states, "Blue Shield's Utilization Review Program reflects their sense of responsibility toward the entire health care system," and then the name of Louis Fares, M.D., is present below that. My point of issue is that the Blue Shield and Blue Cross Programs fail to contribute to the Utilization Review Program in our hospital and in the hospitals which I am acquainted with in Morris County. Being the Chairman of the Hospital Utilization Review Committee we had been requested to conduct several utilization reviews for the "Blues" and when I wrote to them and told them we would be happy to do this if they were willing to fund it since all the time that was spent by utilization review physicians was donated by the individuals. We never did receive an answer to my request. We were later told that the "Blues" were willing to share in the Utilization Review and in the PSRO Reviews which were performed and funded by the government or donated by the individual physicians. I think that if the medical society knew the background and understood the background, this ad is very

misleading especially when it is presented to physicians. The point may be small but I think it is important.

(signed) Andrew G. Hudacek, M.D.

Unscholarly Beginnings Do Not Rule Out Fame

July 20, 1979

Dear Editor:

It is a fascinating but poorly publicized phenomenon that many children whose academic shortcomings and behavior upset their parents and teachers ultimately find their niche and actual fame. Dr. Ronald S. Illingworth, Professor of Child Health in Sheffield, England, has collected ample biographical evidence to support this thesis.

Herein is a compendium arranged in quick-reference fashion which should provide reassurance and solace to anxious parents and teachers. Find the handicap and start quoting.

World-Famous Stutterers:

Moses, Virgil, Charles Darwin, Somerset Maugham

Delayed Talkers:

Albert Einstein, Alessandro Volta (of "voltage" fame)

Dyslexic:

Jan Smuts, Dr. John Hunter, Friedrich Froebel

Poor Spellers:

Napoleon Bonaparte, George B. Shaw, Harvey Cushing

Poor Mathematicians:

Mahatma Gandhi, Benjamin Franklin, Pablo Picasso

Poor Chemist:

Louis Pasteur

Failed School or College:

Emile Zola, Napoleon, Duke of Wellington, Nasser, Galileo

Expelled from School or College:

Charles Thackeray, Edgar Allen Poe, George B. Shaw, Salvador Dali, Sarah Bernhardt, Albert Einstein, Samuel Johnson, Sir William Osler, Benito Mussolini

Underachievers:

Edouard Manet, Eugene Gauguin, Sibelius, Dr. John Hunter, Thomas Edison, Albert Einstein, Leo Tolstoy, Carl Jung, Oliver Goldsmith, Clive of India

(signed) Sol Browdy, M.D.

Patients Who Kill Their Physicians

July 20, 1979

Dear Sir:

I wish to correct a possible misunderstanding which might arise from a statement by Dr. Revitch in his otherwise excellent article, "Patients Who Kill Their Physicians," (*J Med Soc NJ* 76:429-431, June 1979).

The Tarasoff decision has no legal standing in New Jersey. A recent New Jersey court action in McIntosh vs. Milano stated that the question whether or not the duty to disclose such information exists or is possible is a fact to be decided by a jury in that particular case. Dr. Revitch's comment that this type of revelation cannot be considered legally as a breach of confidence is not an established fact in New Jersey at this time.

(signed) John P. Motley, M.D.
President, New Jersey
Psychiatric Association

TEMPLE UNIVERSITY SCHOOL OF MEDICINE

announces the fall programs of clinically relevant continuing medical education programs based upon the concepts of adult education

**October 17 to
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23rd Annual Course "Recent Advances in Medicine" on eight consecutive Wednesdays. Medical School faculty plus five nationally known visiting professors with proven track records as excellent clinical teachers.

**November 2, 1979
(Friday)**

"The Problems of Infection in Obstetrics and Gynecology" at Atlantic City, New Jersey. Medical School faculty plus three visiting professors with national reputations in their field. Lectures and round table discussions.

**November 10, 1979
(Saturday)**

"A Day in Pediatrics," at Helene Fund Medical Center, Trenton, New Jersey, with St. Christopher's Hospital for Children.

**November 14, 1979
(Wednesday)**

20th Annual Isador Forman Postgraduate Course "In the Year of the Child," for professionals interested in the care of the fetus and newborn. Lecture and workshop format.

**November 16, 17, 1979
(Friday & Saturday)**

6th Annual Medical Surgical Conference of the Department of Surgery "Diagnosis and Management of the Severely Ischemic Lower Extremity". For general surgeons who do vascular surgery. Medical school faculty plus nationally recognized authorities in vascular surgery. Program designed to answer practical clinical problems.

**November 17, 1979
(Saturday)**

5th Annual Weiss English Psychosomatic Symposium "Aging". Cosponsored by the Academy on Psychosomatic Medicine. Lectures and workshops. Stewart G. Wolf, M.D. will be the Weiss Memorial Lecturer.

**December 6, 1979
(Thursday)**

"Pediatric Uronephrology Review" at St. Christopher's Hospital for Children.

**December 12, 1979
(Wednesday)**

"Diabetes in the Geriatric Patient." Cosponsored by the Philadelphia Geriatric Center. Medical School faculty plus experts from Yale, Harvard, and the National Institute of Health. Lectures and case discussion.

On-site Category I programs at 35 affiliated Institutions.

For further information contact The Office for Continuing Medical Education (215) 221-4787



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Reduction of Myocardial Injury

Protection of the Ischemic Myocardium

Registration fee: \$125
(includes luncheons and CME certificate)

THE FAIRMONT HOTEL

Philadelphia, Pa.

November 2-3, 1979

This program is designed for physicians in specialty and general practice. Scientific sessions are open to residents, interns, medical students, nurses and technicians without charge.

As an organization accredited for continuing medical education, the Deborah Heart and Lung Center designates this continuing medical activity as meeting the criteria for 11 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

6th Deborah Heart Symposium
Box 369
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RECENT PROGRESS SYMPOSIUM

OCTOBER 20, 1979

(6 Hours CME Credit)

New Developments in the Diagnosis & Treatment of Depression

featuring

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Chief of Clinical Psychobiology Branch of NIMH

and

Other Distinguished Speakers from
Yale University School of Medicine and
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**Fair Oaks Hospital, Summit, N.J. 07901
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Seventh Postgraduate Course in Acupuncture and Pain Control Approved for Category 1 CME

Credits—25 hours

October 5, 6, 7

THE COLLEGE OF PHYSICIANS & SURGEONS OF COLUMBIA UNIVERSITY, AMERICAN COLLEGE OF ACUPUNCTURE, INC., NEW YORK SOCIETY OF ACUPUNCTURE FOR PHYSICIANS & DENTISTS, INC., & AMERICAN ACADEMY OF ACUPUNCTURE, INC. are jointly sponsoring the seventh Postgraduate Course & Workshop in Acupuncture & Pain Control for advanced and beginner students at the Barbizon Plaza Hotel, New York City, for 25 credit hours in Category 1 towards the AMA's Physician's Recognition Award; also approved by the New York State Boards for Medicine & Dentistry for 25 credit hours toward New York State acupuncture registration.

Among the principal speakers will be Candace & Agu Pert, Ph.D.'s of the National Institute of Mental Health, discussing their recent work with endorphins and pain. For information & application contact:

S.J. Yue, M.D., Secretary
New York Society of Acupuncture for
Physicians & Dentists, Inc.
115 East 61st Street
New York, New York 10021

(212) 870-6671 Mon. to Fri. 9 AM to 1 PM

CME CALENDAR

ANESTHESIOLOGY

Nov.

- 20 Annual Meeting**
Ramada Inn, Clark
NJ State Society of Anesthesiologists and AMNJ

MEDICINE (includes Family, Internal, and General Medicine and Dermatology)

Oct.

- 3 Cardiology Conferences**
4-6 p.m.—Rutgers Medical School, Piscataway
CMDNJ, Somerset County Heart Assoc., and AMNJ

- 3 Medical Lecture Series**
10 1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

- 24**
31
6 EKG Course for Primary Care Physicians
8:30 a.m.-5:30 p.m.—Sheraton Heights Hotel, Hasbrouck Heights
(South Bergen Hospital and AMNJ)

- Cancer Update 1979**
6 9 a.m.-5 p.m.
7 9 a.m.-12 noon—Meadowlands Hilton, Secaucus
(Bergen County Unit, American Cancer Society, Bergen County Medical Society and AMNJ)

- 7 Seminar—Varied Topics**
8:30 a.m.-5 p.m.—Sheraton Hotel, East Brunswick
(American College of General Practitioners in Osteopathic Medicine and Surgery and AMNJ)

- 9 Hepatitis Update**
8:30-9:30 p.m.—Riverside General Hospital, Secaucus
(Riverside General Hospital and AMNJ)

- 10 NJ Society of Critical Care Medicine**
8:45 a.m.-4 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)

- 10 Preservation of the Ischemic Myocardium**
17 Clinical Disorders of Respiratory Control
24 Geriatric Medicine
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

- 10 The Nephrotic Syndrome**
17 Problems in Pharmacotherapy
24 To be announced
31 To be announced
9:30-11 a.m.—Bergen Pines County Hospital, Paramus

(Bergen Pines County Hospital and AMNJ)

- 10 Alcoholism and Drug Abuse**
9-11 p.m.—Holiday Inn, East Orange
(Essex County Medical Society and AMNJ)

- 11 Tumor Conference**
12 noon—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

- 11 Mitral Valve Prolapse**
8-9:30 p.m.—Deborah Heart and Lung Center, Browns Mills
(Burlington County Medical Society and AMNJ)
Thromboembolism and Fluid Replacement in Postoperative Care

- 12** 8:30 a.m.-5 p.m.
13 8:30 a.m.-noon—New Jersey Medical School, Newark
(CMDNJ and AMNJ)

Cardiovascular Care Workshop

- 13** 8:45 a.m.-6 p.m.
14 9:30 a.m.-12 noon—Sheraton Post Inn, Cherry Hill
(American Heart Association, NJ Affiliate and AMNJ)

- 13 Total Parenteral Nutrition**
8:30 a.m.-1:30 p.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

- 13 Acute Pulmonary Insufficiency**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

- 16 New Cytologic Techniques**
23 Ulcer Therapy and Contra-indicated Drugs
8-9 a.m.—Garden State Community Hospital, Marlton
(Garden State Community Hospital and AMNJ)

- 17 Update on TPN and Neoplastic Disease**
8:45 a.m.-5 p.m.—John F. Kennedy Medical Center, Edison
(John F. Kennedy Medical Center and AMNJ)

- 17 Sexually Transmissible Diseases**
8 a.m.-4:30 p.m.—Rutgers Medical School, Piscataway
(AMA, MSNJ, AMNJ, CMDNJ)
18 Peripheral Vascular Complications of Diabetes Mellitus
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

- Current Concepts in Internal Medicine—Digestive Diseases**
20 8 a.m.-5:30 p.m.

- 21** 8:30 a.m.-5 p.m.—NJ Medical School Newark
(CMDNJ and AMNJ)

Internal Medicine—Cardiology

- 20** 8 a.m.-5:30 p.m.
21 8:30 a.m.-4:20 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

- 22 Inflammatory Bowel Disease**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

- 24 Rheumatic Disease—The Allied Specialist's Approach**
9 a.m.-2:20 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)

- 25 Brain Biochemistry and Behavior**
1:30-5:30 p.m.—Drew University, Madison
(Drew University, CIBA-Geigy Pharmaceutical Division and AMNJ)

- 27 Collagen Diseases in Children**
8-10 a.m.—Newcomb Hospital, Vineland
(Newcomb Hospital)

- 31 Myasthenia Gravis**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

Nov.

- 7 The Difficult Patient with Diabetes**
8:30 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(American Diabetes Association, NJ Affiliate, and AMNJ)

Urinary Tract Infection

- 14 To be announced**
21 Limiting Myocardial Infarct Size
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

- 7 Medical Lecture Series**
14 1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

- 28**
13 Malignant Hypertension
8:30-9:30 p.m.—Riverside General Hospital, Boonton
(Riverside General Hospital and AMNJ)

- 14 Advances in Pulmonary Diseases**
9 a.m.-5 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)

- 14 Treatment of Chronic Bronchitis**
21 Neuroendocrinology in Clinical Practice
28 Differential Diagnosis of Pneumonia
9-11 a.m.—Roosevelt Hospital, Menlo Park

BODY CT / NEURO CT

A TWO-PART SYMPOSIUM ON COMPUTED TOMOGRAPHY
OCTOBER 10-12, 1979

PRESENTED BY THE DEPARTMENT
OF DIAGNOSTIC RADIOLOGY
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UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

BODY CT

PROGRAM

NEURO CT

October 10, morning

Welcome—John M. Dennis, M.D., and Joseph Whitley, M.D.

Moderator: Nancy Whitley, M.D.

CT of the Larynx — Stephen Cisternino, M.D.

CT of the Pulmonary Nodule — Stanley Siegelman, M.D.

CT of the Mediastinum and Pleura — Charles Putman, M.D.

CT Scanning of the Pancreas — Ralph Alfidi, M.D.

CT Scanning of Kidneys and Adrenals — Stanley Siegelman, M.D.

Comparative Aspects of Ultrasound and CT of the Retroperitoneum — Conrade C. Jaffe, M.D.

October 10, afternoon

Moderator: Morgan Dunne, M.D.

CT of the Pelvis — Nancy Whitley, M.D.

CT in Musculoskeletal Neoplasms — Peter Mueller, M.D.

Sequential CT Scanning after IV Contrast — Ralph Alfidi, M.D.

Clinical Application of Multiplanar Reconstruction in CT of the Abdomen — Conrade C. Jaffe, M.D.

Interventional CT — Peter Mueller, M.D.

October 11, morning

Moderator: Stephen Cisternino, M.D.

Global Abdominal Anatomy by Ultrasound and Computed Tomography — Morgan Dunne, M.D.

Computed Tomography of Trauma — Edward Drury, M.D.

New Developments in CT Technology — John Perry

The Use of CT in Radiation Therapy Planning — Ralph Scott, M.D.

October 11, midday: Workshop sessions at the University of Maryland Hospital and Johns Hopkins Hospital will demonstrate CT diagnostic activities in clinical settings.

Location: INTERNATIONAL HOTEL, Baltimore-Washington International Airport.

Pre-registration: Early pre-registration by mail is encouraged since conference facilities necessitate limited enrollment. Registration, with a \$15 late fee, will be possible on a space available basis at the International Hotel, 7:30 am, October 10 and 10:00 am, October 11.

Fee:

	Physicians	Residents, Interns and Other Professionals
Full 3-day course:	\$200	\$135
Body CT session only:	\$125	\$ 80
Neuro CT session only:	\$125	\$ 80

The total registration fee, payable in advance, includes the cost of instructional materials, coffee breaks, lunches, and reception.

Credits: 20 credit hours in Category I of the Physician's Recognition Award, American Medical Association, for the entire course.

Supported by an educational grant from Pfizer Medical Systems, Inc.

October 11, afternoon

Moderator: Krishna C.V.G. Rao, M.D.

Functional CT Anatomy — Mokhtar H. Gado, M.D.

Sensitivity and Specificity of CT Scanning in Intracranial Neoplasm — Sadek K. Hilal, M.D., Ph.D.

CT in Sellar and Parasellar Lesions — Fred J. Hodges, III, M.D.

Normal and Abnormal CT Anatomy of Intracranial Structures — Sadek K. Hilal, M.D., Ph.D.

October 12, morning

Moderator: Richard F. Mayer, M.D.

CT in Stroke — Irvin Kricheff, M.D.

Intracranial Anomalies — Derek C. Harwood-Nash, M.D.

CT in Certain Pediatric Conditions — Krishna C.V.G. Rao, M.D.

Moderator: Harvey H. Levine, M.D.

CT in Head Trauma — Pulla R.S. Kishore, M.D.

CT in Degenerative Brain Disease — Giovanni DiChiro, M.D.

CT in Infection — S.H. Lee, M.D.

October 12, afternoon

Moderator: Thomas B. Ducker, M.D.

Computed Tomography/Metrizamide in Evaluation of

Pediatric Spine — Derek C. Harwood-Nash, M.D.

CT/Metrizamide in the Adult Spine — Mokhtar Gado, M.D.

Use of Metrizamide and Alternative Methods of Evaluating Posterior Fossa Lesions — Irvin Kricheff, M.D.

Recent Trends in Neuro-imaging Modalities — Giovanni DiChiro, M.D.

Moderator: Giovanni DiChiro, M.D.

Panel Discussion

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- (*Middlesex General Hospital and AMNJ*)
- 15 Newer Therapeutic Regimes in Hypertension**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 21 Use of Prednisone in Pulmonary Disease**
11:30 a.m.-1 p.m.—VA Medical Center East Orange
(*VA Medical Center and AMNJ*)

NEUROLOGY/PSYCHIATRY

- Oct.**
- 3 Treatment of Syncopal Episodes**
- 31 The Borderland between Neurology and Psychiatry**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 3 Death and Dying and the Family**
- 17 Family Therapy (Videotape)**
- 24 Family Therapy**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 3 Carotid Disease**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 3 The Child at Risk**
- 10 9 a.m.-3 p.m.—Carrier Foundation, Belle Mead**
(*Carrier Foundation and AMNJ*)
- 4 Tension Type Headaches**
- 11 Computers in Psychiatry—Use and Abuse**
- 18 When, How, and Why To Use Antidepressants**
12 noon-1 p.m.—Carrier Foundation Belle Mead
(*Carrier Foundation*)
- 5 Psychiatric Lecture Series**
- 12 1:30-5 p.m.—Trenton Psychiatric**
- 19 Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 26 Grand Rounds in Psychiatry and Mental Health Science**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 10 Use of the Dream in Psychoanalytic Psychotherapy**
- 17 Same**
- 24 Same**
- 31 Psychotherapy with the Borderline Patient**
8-10 p.m.—Hackensack Hospital
(*NJ Psychoanalytic Society and AMNJ*)
- 13 Developmental Dyslexia**
9:30 a.m.-1 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center and AMNJ*)
- 15 Neuroscience Conferences**
- 22 11:30 a.m.-12:30 p.m.—Bergen Pines**
- 29 County Hospital, Paramus**
(*Bergen Pines County Hospital and AMNJ*)
- 17 Relationship of Psychiatry to Social Work, Public Health, and Neurology at the Turn of the Century**
1:30-3 p.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)

- 17 Psychiatry Today and in the Future**
8:30-10 p.m.—Mayfair Farms, West Orange
(*Tri-county Chapter, NJ Psychiatric Assn. and AMNJ*)
- 18 Mythology and Content of Scientific Cosmetology**
8:30-10:30 p.m.—Hackensack Hospital
(*NJ Psychoanalytic Society and AMNJ*)
- 31 The Borderland between Neurology and Psychiatry**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

- Nov.**
- 1 Prediction Methods for Doses in Clinical Psychiatry**
- 8 Neuroleptics: When, How, Why, and Why Not?**
- 15 Cognitive Therapy of Depression**
- 29 Schizophrenia, Tardive Dyskinesia and Tourette Syndrome**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 2 Psychiatric Lecture Series**
- 9 1:30-5 p.m.—Trenton Psychiatric**
- 16 Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 23 Neuroscience Conferences**
- 30 11:30 a.m.-12:30 p.m.—Bergen Pines**
- 19 County Hospital, Paramus**
(*Bergen Pines County Hospital and AMNJ*)
- 7 Hyperventilation Syndrome**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 7 Psychotherapy with the Borderline Patient**
8-10 p.m.—Hackensack Hospital
(*NJ Psychoanalytic Society and AMNJ*)
- 7 Couples Therapy**
- 14 Evaluation of Adolescents**
- 21 Evaluation of Adolescents-Non-Psychotic**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 14 Grand Rounds in Psychiatry and Mental Health Science**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 28 Psychological Issues and Illness**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)

OBSTETRICS/GYNECOLOGY

- Oct.**
- 2 Tubal Reconstruction**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)
- 3 Lectures in Obstetrics and Gynecology**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 3 Grand Rounds in Obstetrics and Gynecology**
- 10 3-5 p.m.—Rotates between CMDNJ-**
- 17 College Hospital, Newark Beth Israel**
- 24**

- 31 and St. Michael's Medical Centers, Newark, St. Joseph's Hospital and Medical Center, Paterson, and Jersey City Medical Center**
(*CMDNJ and AMNJ*)
- 4 Grand Rounds in Obstetrics and Gynecology**
- 11 4-5 p.m.—College Hospital, Newark**
- 18 (CMDNJ and AMNJ)**
- 25**
- 10 Obstetrics/Gynecologic Malpractice**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)

- Nov.**
- 1 Grand Rounds in Obstetrics and Gynecology**
- 8 4-5 p.m.—NJ Medical School, Newark**
- 15 (CMDNJ and AMNJ)**
- 29**
- 7 Distinguished Lectures in Obstetrics and Gynecology**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 7 Grand Rounds in Obstetrics and Gynecology**
- 14 3-5 p.m.—Rotates between CMDNJ**
- 21 College Hospital, Newark Beth Israel**
- 28 and St. Michael's Medical Centers, Newark, St. Joseph's Hospital and Medical Center, Paterson, and Jersey City Medical Center**
(*CMDNJ and AMNJ*)

PATHOLOGY

- 2 Hypercalcemia Associated with Hidden Malignancy**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

PEDIATRICS

- 27 Collagen Disease in Children**
8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)

GENERAL SURGERY

- Oct.**
- 2 Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 6 Staplers**
8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)
- 11 Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)

- Nov.**
- 6 Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)

SURGICAL SPECIALTIES (includes ENT, neurosurgery, ophthalmology, orthopedic, plastic, and vascular surgery)

- Oct.**
- 9 Sports Medicine Related to Injuries of the Foot**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)

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- 23 Clinical Microsurgery: Replantation to Impotency**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- Nov.
- 19 Occlusive Cerebral Vascular Disease**
12:30-1:30 p.m.—West Hudson
Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 27 Basal Cell Carcinoma: Eyelid and Eyebrow Reconstruction**

8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

MISCELLANEOUS

Oct.

- 3 What Can We Do About Our Number One Health Hazard?**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 4 Organization of Developmental Information**
- 11 Oogenesis**

- 18 Spermatogenesis**
- 25 Cytoplasmic Information**
4-6 p.m.—Institute for Medical
Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)

Nov.

- 1 Developmental Biology Course**
- 8 4-6 p.m.—Institute for Medical Research**
- 15 Copewood St., Camden**
- 29** (*Institute for Medical Research and AMNJ*)

OBITUARIES

Dr. Irving Chrisman

A former President of the Passaic County Medical Society, Irving Chrisman, M.D., died in Paterson on July 12. Born in 1907 and graduated from the New York University College of Medicine, class of 1931, Dr. Chrisman pursued a career in obstetrics and gynecology after completing a residency in that field at Bellevue Medical Center in New York. He was board certified in obstetrics and gynecology and a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists. He had been a member of the senior staff at St. Joseph's Hospital, Paterson, and chief of the gynecological clinic at Bellevue Medical Center in New York.

Dr. Vincent P. DePietro

We just have learned of the death at his home on May 11, of Vincent P. DePietro, M.D., after a prolonged illness. A native of New Jersey, born in 1914, Dr. DePietro earned his medical degree from Georgetown University School of Medicine in 1942 and pursued graduate studies in obstetrics and gynecology at New York Post graduate Medical School and Margaret Hague Maternity Hospital in Jersey City. A member of our Hudson County component, he practiced in Weehawken and

Union City and was on the staff at St. Mary's Hospital in Hoboken, North Hudson Hospital in Weehawken, and Margaret Hague Hospital in Jersey City. He was board certified in his specialty and was a Fellow of the American College of Surgeons, of the International College of Surgeons, and of the American College of Obstetricians and Gynecologists. During World War II, Dr. DePietro served in the medical department of the AUS.

Dr. J. Paul Kelly

One of Morris County Medical Society's senior members, Joseph Paul Kelly, M.D., died on July 6. A native of Alabama, Dr. Kelly was graduated from Howard University Medical School in 1933 and pursued a career in general practice in Newark and Morristown. He had been affiliated with the Morristown Memorial and All Souls Hospitals in Morristown. Dr. Kelly was active in medical society affairs and had been a delegate from his County to MSNJ's House of Delegates. He was 70 years old at the time of his death.

Dr. Thomas M. Morris

Word just has been received of the death on June 24 of Thomas M. Morris, M.D. A native of Williamsport, Pennsylvania, Dr. Morris was graduated

from the Medical College of the University of Pennsylvania, class of 1916. He came to New Jersey and established a practice in urological surgery in Plainfield and was affiliated with the Muhlenberg Hospital there. Dr. Morris was a Fellow of the American College of Surgeons and a member of the American Urologic Association and of the prestigious New Jersey Society of Surgeons. He retired in the early 1960s and moved to Fort Lauderdale, Florida. He was 88 years old at the time of his death.

Dr. Philip E. Ramirez

A member of our Cumberland County component, Philip E. Ramirez, M.D., died on May 9 in Newcomb Hospital, Vineland, following a myocardial infarction. A native of New York City, Dr. Ramirez received his doctorate of medicine from New York University College of Medicine in 1952 and took residencies in general and orthopedic surgery at the Naval Hospital in Bethesda, Maryland and in neurosurgery at the University of Virginia Hospital in Charlottesville, Virginia. Before coming to New Jersey in 1963, first to Woodbury and later to Vineland, he had practiced at the United States Naval Hospital in Philadelphia. He had been affiliated with the Underwood Hospital in Woodbury and Kessler Memorial Hospital in Hammon-

Dr. Joseph F.A. Rubacky

One of Passaic County's senior emeritus members, Joseph F.A. Rubacky, M.D., formerly of Passaic, died on May 8. A native of New Jersey, born in 1897, Dr. Rubacky was graduated from Fordham University College of Medicine in 1918 and received a bachelor of law degree from Rutgers University in 1927. He took graduate work in industrial surgery and orthopedics and practiced physical medicine for many years. Just before his retirement to Fort Lauderdale, Florida, he had been director of the department of physical medicine at St. Mary's Hospital in Passaic. He was a Fellow of the American Board of Legal Medicine and served as its vice president during one term. He was a past president of the New Jersey Society of Physical Medicine. Dr. Rubacky was active in community affairs and was commissioner of health in Passaic in the early 1920's. He was a member of the Passaic County Planning Commission and of the Passaic Board of Education. Dr. Rubacky served in the medical corps of the U.S. Army during World War I.

Dr. Irving M. Silber

Irving M. Silber, M.D., a member of our Middlesex County component, died on July 11. Born in New York City in 1914, Dr. Silber was graduated from the Medical School of the University of

Pennsylvania in 1941 and practiced internal medicine in Middlesex County for many years. He was board certified in his chosen field and a Fellow of the American College of Physicians. Dr. Silber had been affiliated with St. Peter's and Middlesex General Hospitals in New Brunswick.

Dr. G. Ruffin Stamps

The former chief of surgery at the Atlantic City Medical Center died at his home on July 22. A native of Alabama, Dr. Stamps earned his medical degree from Jefferson Medical College in 1929 and took a surgical residency at the Atlantic City Medical Center. He initially established a general practice in Pleasantville, and after serving three years with the Department of Medicine of the AUS during World War II, he opened an office in Atlantic City for the practice of surgery. Dr. Stamps served a term as president of the Atlantic City Hospital staff and was chief of surgery for 12 years and director of surgery for three of those years; he also was a member of the hospital's board of governors. Dr. Stamps retired in 1963 because of illness. He was a Fellow of the American College of Surgeons and was active in medical society affairs, having served as president of his county medical society. He also was a member of the board of directors of the Atlantic County Association for Mental Health. Dr.

Stamps was 76 years old at the time of his death.

Dr. Frances L. Steinman

Frances L. Steinman, M.D., a member of the Middlesex County Medical Society, died on July 5 at her home. Born in New York City, Dr. Steinman earned her medical degree at Long Island College of Medicine in 1936 and practiced pediatrics in Metuchen and Perth Amboy for many years. She had been affiliated with St. Peter's and Middlesex General Hospitals in New Brunswick and with the Perth Amboy General Hospital. Dr. Steinman was 85 years old at the time of her death.

Dr. Leo J. Ward

One of Ocean County's senior members, Leo J. Ward, M.D., died at Mercer Medical Center, Trenton, on July 18. Born in Gloversville, New York in 1893, and graduated from New York Medical College in 1917, Dr. Ward practiced general medicine in Elizabeth for 55 years before retiring to Point Pleasant in 1972. He was certified by the American Board of Radiology and a Fellow of the American College of Radiology. He had been affiliated with St. Elizabeth and Alexian Brothers Hospitals in Elizabeth. A brother, Jack L. Ward, M.D., a member of the Mercer County component, is a Trenton psychiatrist.

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Journal of
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Maternal Deaths

J. P. Thompson, M.D.

Left Atrial Myxoma

A. E. Millman, M.D., et al.

Left Atrial Myxoma

Barry B. Galton, M.D.

Pseudotumor of Ventricle

Ira Berger, M.D., et al.

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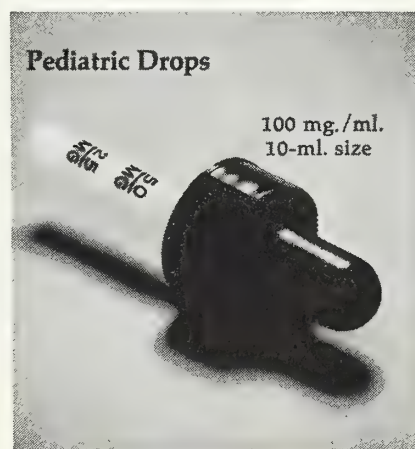
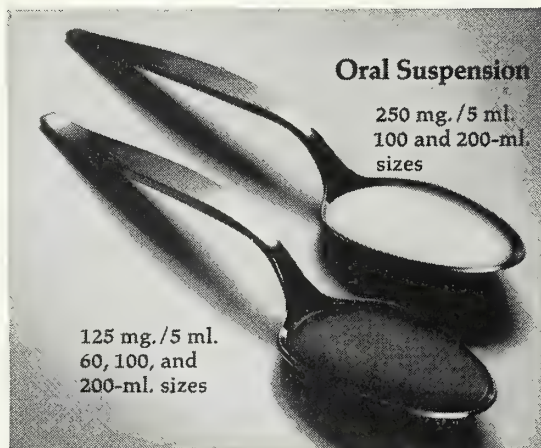
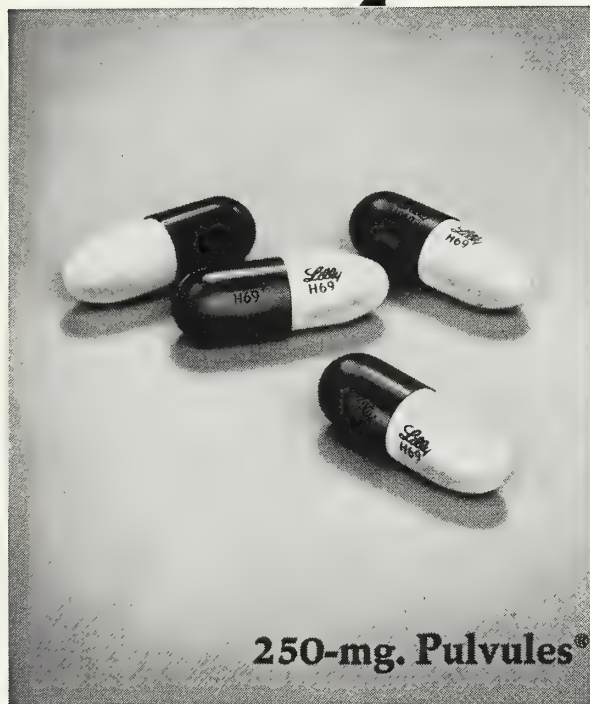
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Cover

The cover photograph of the Cooper River, taken at sunset in the fall of 1976, was provided by John L. Krause, Jr., M.D., a member of our Camden County component, who has supplied covers for *The Journal* in the past—this year in January and May.

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The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

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Accident Facts, Chicago, Illinois, National Safety Council, 1974.

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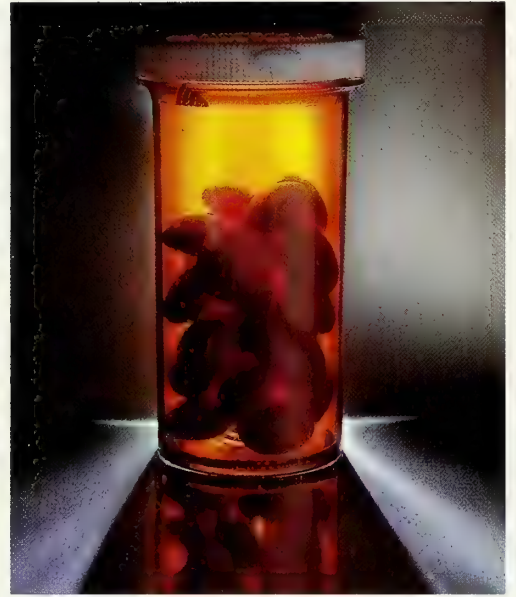
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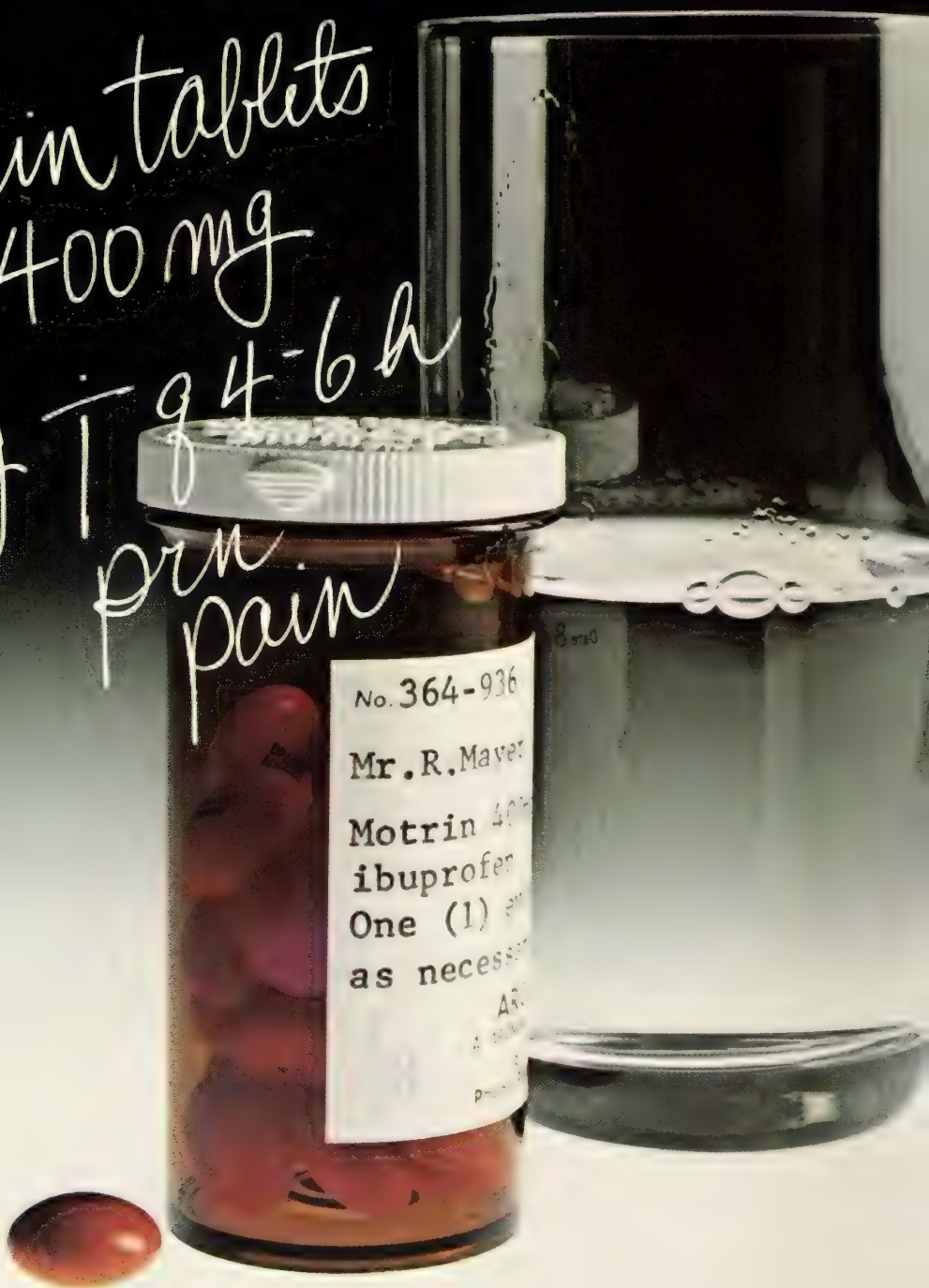
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Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

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Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

* 0 = No relief 1 = Partial relief 2 = Complete relief

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Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

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ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
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- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

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Motrin^(R) (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS)

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial

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Do not exceed 2400 mg per day

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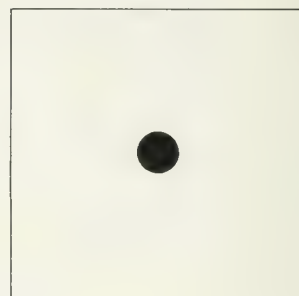
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August, 1979

A blood clot the size of this dot can cause a Heart Attack.



Or a stroke.

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How to detect them. How to treat them. How to keep them from happening.

We're fighting hard. With new drugs. New kinds of treatment. Better ways to help heart attack and stroke victims return to a normal life.

And it's only a part of the total war we're waging against the number one cause of death in this country: heart disease and stroke.

But we can't fight without your money. When the Heart Association volunteer asks for your dollars, be generous.

The blood clot is small, the problem is enormous.

The American Heart Association 
WE'RE FIGHTING FOR YOUR LIFE

Tumors of the Heart Revisited

Cardiac metastases are far more common than primary tumors of the heart, originating most often from cancers of the breast or lung, lymphomas and melanomas. Myxomas comprise from 35 to 50 percent of primary cardiac tumors and usually are found in the left atrium. Only five to ten percent of all cardiac tumors interfere with function enough to produce clinical symptoms and signs. These findings include intractable, rapidly progressive heart failure, otherwise unexplained arrhythmias and conduction defects, rapidly accumulating pericardial effusions, especially hemorrhagic, embolic phenomena, both systemic and pulmonary, a variety of valvar dysfunctions, and constitutional symptoms such as fever, weight loss, and generalized weakness. The majority of cardiac tumors produce no symptoms or signs and, until recently, were not diagnosed except with invasive methods.

The advent of echocardiography, conventional and two-dimensional, as well as myocardial scintigraphy has revolutionized the diagnostic approach to cardiac tumors. Any "non-invasive" laboratory worth mentioning has its private stock of echocardiographic myxomas and other neoplastic niceties. In this issue of *The Journal*, Millman *et al.* (p. 749) present a fairly typical case of left atrial myxoma studied by conventional M-mode echocardiography, two-dimensional sector scanning, and cardiac catheterization with pulmonary angiography. Tumor volumetrics obtained by sector scanning corresponded amazingly well with angiographic estimates. I would agree that sector scanning is "helpful in preoperative evaluation," but I doubt that "the risk of cardiac catheterization thus may be avoided" because most cardiac surgeons still insist on the omniscient angiogram for

"proof-positive."

Galton's case report (p. 754) describes a remarkable instance of myxoma in an elderly man whose only complaint was generalized weakness owing to an iron-deficiency anemia. There were no cardiac abnormalities except transient atrial arrhythmias and agonal pulmonary edema. Because of the paucity of cardiac findings, echocardiography was not performed and the diagnosis was established only at autopsy. While antemortem diagnosis of myxoma is essential since most of these tumors are surgically curable, I fail to see how this could have been accomplished in Galton's patient. Perhaps echocardiograms should be obtained in all patients with embolic phenomena, valvar dysfunction, or "constitutional" symptoms. On the other hand, the cost of such a "screening" program might be prohibitive.

Finally, Berger *et al.* (p. 758) report a rare example of pseudotumor of the left ventricle, i.e., a calcified papillary muscle in a child with congenital mitral valvar dysfunction. Echocardiography showed a mobile mass inferior to the mitral valve and inseparable from the left ventricular posterior papillary muscle, while angiocardiology indicated a calcified mass in the same region. Surgical exploration revealed an area of calcification in a thickened posterior papillary muscle as well as a congenitally abnormal mitral valve. The echocardiographic findings in this pseudotumor are unique and merit careful review by all readers.

By publishing this triad of case reports* simultaneously, *The Journal* is striving to convey relatively new information about tumors of the heart, a diagnostic category that lay dormant for many decades.

Edwin L. Rothfeld, M.D.

Maternal Mortalities: Utilization of Data

In 1977 in New Jersey, there were 19 maternal deaths and 93,786 live births, giving a maternal mortality rate of 20.3 per 100,000 live births or one in 4926 births. Of these, 15 were direct maternal deaths, or one in 6252 births. Each death has been reviewed, abstracted, defined (in terms of cause, race, geographic distribution, age, parity, type of delivery, and so on) and discussed. Ultimately, the collective data are reported to the Health Department and published in *The Journal* of the Medical Society of New Jersey (p. 735, this issue).

This activity of the Subcommittee of Maternal Mortality

Review obviously results in a huge amount of information. The major questions I would like to propose are: What shall we do with this information? How can we, as clinicians, use these data to educate ourselves? What is the proper forum for effective education?

A maternal mortality is much more than a statistic. It is interminably tragic to the family and evokes the most privately primeval of reactions in the physician. Sir Richard Croft, after Princess Charlotte of England died during his

*Another report of atrial myxoma appeared in the March 1979 issue of *J Med Soc NJ* 76:213-215.

attendance of her labor, committed suicide. Undeniably, this is a rather extreme (and unproductive) method of coping with a maternal mortality, but it is true that a maternal death provokes a profound sense of inadequacy; an appetite for self-recrimination that is nearly insatiable—nearly, but not quite. Satiation comes with the realization that our clinical management of the patient may be adjudicated, not necessarily by our peers, but by a more materialistic mechanism, the courts. Our depression passes and is replaced by fear.

These are normal instincts reflecting our Janus-like concerns for both the universal community of “motherhood” and the more nuclear community of our “selves.” Frequently during this emotional turnabout something is lost. Why did the patient die? What might have been done differently?

The courts do not constitute an appropriate forum for the clinical exploration of a maternal mortality. The entire courtroom discussion is inquisitive. From these adversary-like conversations come an offal heap of minor points and “silver-tongued” trick phrases. Courtroom exercises do not answer what was right or what was wrong, but rather who wins and who loses. Undeniably negligence must be rectified (and materially rectified) and this is indeed the purview and duty of the courts, but rarely does this process sharpen our clinical senses or improve our care.

Given that suicide and the courts are both inappropriate solutions to our original questions, what remains?

FORGET IT

In a recently published article in the *American Journal of Public Health* (September 1977) it was pointed out that states with maternal mortality committees do not show any greater decline in maternal mortality rates when compared to states without maternal mortality review committees. At first reading this observation poses an argument that is circuitous at best, and destructive at worst. From it, one might conclude that maternal mortality committees induce, or increase, maternal mortalities or, at the very least, do absolutely nothing to change the course of events. Yet, is it not true that collecting the data and simply sequestering them away in a statistical survey buried in a state ledger is surely a very sophisticated method of forgetting them? If maternal mortality committees are merely intermediaries in the care and feeding of computers and statisticians, let's abandon them.

PUBLISH THE STATISTICS

They are perhaps interesting (if you're an epidemiologist), and perhaps unbearable (if you're reading them at 3 a.m. while your patient is in labor), but most probably, unread. They may help with the answer to a “recertification” multiple-choice question. There is no doubt that knowledge of the statistical and demographic overview is very helpful in correcting the system-related problems (availability of fresh frozen plasma, maternal transport, and so on) but not very helpful with that 3 a.m. decision.

PUBLISH THE CASES

This is modestly effective but somewhat dangerous. Effectiveness is decreased because the material may not reach the intended audience. Consider the following. Does the actively involved obstetrician look to his state journal for clinical direction? Are the obstetrician's clinical journals prepared to publish another case report and reiterate the day-to-day management of hypertensive disease or abruptio placentae or ectopic pregnancy? Is the clinician, who is most in need, reading this or any other journal?

Publication of the case reports also is compromised effectively by the “how-could-he-have-done-that?” syndrome. The reviewer, however informed and concerned, invariably falls into the “grand inquisitor” trap. Again, the adversary position, again, the winner and the loser. The reviewer is “sanctified by print” and it is frequently perceived by the reader that the reviewer must be omniscient. He has the imprimatur of the printed page. But the reviewer well may be wrong or at least not aware of local problems, important circumstances, or some unique factors. The reviewer is not speaking “ex cathedra.” When I publish a paper I secretly hope it does not embarrass me in less than three years.

Case reports, however disguised and adroitly disfigured, are very tasty morsels for some very voracious canines (although they themselves prefer the designation, “Hounds of Heaven”). This brings us back again to the arena of the courts. A strong reviewer, indeed, effectively can fight off this legal attack; he adequately but insubstantially can alter the case report; he can delay publication to defuse its immediacy; he can “burn the records” if they are requested. To some extent these maneuvers should be used because publication of the case report is an advertisement that something is wrong, an attention-getting device that may reach a rather wide audience.

Therefore, publishing selected cases in *The Journal* is appropriate and one acceptable method of education. I would advocate this strongly. *The Journal* should make its pages available for periodic publication of specific maternal mortalities.

THE CONFERENCE

Maternal mortalities must be talked about not necessarily at national meetings, or only at state society or medical school meetings, but at the hospitals, where the action is. The maternal mortality committee members must give up a year of Saturday mornings or Wednesday afternoons and select the representative cases and bring them to the hospitals. They must talk about them, be specific, talk to the diagnosis of ectopic pregnancy, the handling of the eclamptic. Talk not in terms of “a study of Iowa shows . . .,” but rather how much magnesium sulfate to give, what is the radio-receptor assay, why did Mrs. so-and-so receive morphine, what is the significance of sudden weight gain? Of course, the practitioner who needs it most may not attend the hospital conference, but some of his peers will. It is impossible to be involved in a treacherous obstetrical problem without consulting with a wide sampling of fellow clinicians. Peer pressure can be considerable. Thus it would appear to be a responsibility of the various hospitals to assign specific times (once or twice a year) for maternal mortality conferences and the equal responsibility of knowledgeable members of the committee to conduct these conferences in the most open, productive, and specific manner as possible.

Perhaps the best mechanism for the planned hospital conference is for the committee member to select a topic, i.e., ectopic pregnancy, bring the appropriate case histories and discuss them. What level of hCG is required for a positive hemagglutination pregnancy test? How often do you feel an adnexal mass or have a positive pregnancy test? How do you take a menstrual history? Of course these aren't the most academically titillating discussions. They aren't about recombinant DNA or fetoscopic technics.

They're about patients.

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Concurrent Quality Assurance (CQA)

Private Initiative in Professional Standards Review Organizations (PIPSRO), "a national project (funded by the W.K. Kellogg Foundation) which enlisted the medical and hospital profession in developing new and effective methods for the PSRO monitoring process" studied the feasibility of making CQA the principal function of the Review—Coordinator—Physician Adviser team.*

Studies for periods of seven to twelve months covering the records of approximately 9,000 patients were made in three hospital groups, totaling sixty-eight hospitals.

The patients studied were admitted to the hospital for treatment of one of seven conditions: acute myocardial infarction, bacterial pneumonia, bacterial urinary tract infection, massive upper gastrointestinal bleeding, acute gastroenteritis (in children), acute appendicitis, and cholecystitis or cholelithiasis. Essential criteria of care, requiring documentation in the patient's records included the following:

- (1) facts substantiating the diagnosis;
- (2) presence or absence of preexisting or coexisting diseases or conditions which independently and importantly may modify the outcome;
- (3) presence or absence of complications or conditions related to the patient's disease which importantly may influence choice of treatment and outcome;
- (4) application of treatments or procedures whose efficiency is established scientifically; and
- (5) exclusion of contra-indicated treatments or procedures.

The hospital groupings were:

Experimental hospitals—In this group: the medical staffs voted to comply with the essential criteria in the care of the

patients except when good medical judgment dictated otherwise. The review coordinator abstracted the pertinent data, the physician adviser noted differences between care being given and the essential criteria. Immediate outcomes of treatment were noted.

Control hospitals—The same information was abstracted concurrently but the attending physicians were not informed when departures from the criteria were observed. Immediate outcomes of treatment were noted.

Matched non-control hospitals—Here, corresponding data were collected retrospectively after the patients had been discharged.

The CQA study, which cost approximately \$1.25 per case and took an average of eleven minutes per patient record, demonstrated the effect of adherence to essential criteria of care or outcomes as follows:

—There was no relationship between the immediate outcomes of care and the degree of pertinent detail in the medical record.

—There was a consistent relationship between improved results of care and adherence to certain essential treatment criteria.

—The length of hospital stay did not increase due to adherence to the essential treatment criteria; in fact, a high degree of adherence shortened the length of stay.

The study showed that CQA is feasible, compatible with utilization reviews required by PSROs, and cost effective. If such evaluations can improve the quality of care in hospitals and shorten length of stay by emphasizing adherence to acceptable treatment criteria, each physician and each hospital medical staff should assume a positive attitude toward concurrent quality assurance (CQA). A.K.

Impaired Physicians†

Human beings may become unable to function appropriately because of physical injury or disease, drug or alcohol abuse, psychiatric disorders—or a combination of these problems. Physicians are not immune to such miseries, but the impaired physician may be the last one to recognize his plight.

The Medical Society of New Jersey, through its Commit-

tee on Impaired Physicians, is in a position to assist. Colleagues, family members, and friends are urged to come to the aid of the physician who needs help. After all, he probably has done the same for them and for many patients during his medical career.

Give a colleague in need a hand. Help his Society to help him. A.K.

*The PIPSRO Summary. Ann Arbor, Michigan, Health Administration Press, 1978.

†See page 767, this issue.

~~should~~^{must} What you know about the newly enacted New Jersey Drug Substitution law

As of April 23, 1979, the state dramatically changed the lawful way of prescribing drugs and of writing a prescription. Until then, writing the brand name of a drug on the prescription was enough to ensure that the same brand-name drug would indeed be dispensed. Now that no longer suffices. Unless the

physician takes the necessary extra steps, for many drugs the pharmacist must substitute a lower-cost brand name of that drug or a lower-cost "equivalent" generic drug contained in the latest list of interchangeable drug products published by the Drug Utilization Review Council.

New prescription form shows two prescribing options

The law states:

- "Every prescription blank shall be imprinted with the words 'substitution permissible' and 'do not substitute' and shall contain space for the physician's or other authorized prescriber's initials next to the chosen option."

NOTE:

- "For prescriptions filled other than by mail, the consumer may, if a substitution is indicated and prior to having his prescription filled, request the pharmacist or his agent to inform him of the price savings that would result from substitution. If the consumer is not satisfied with said price savings he may, upon request, be dispensed the drug product prescribed by the physician. The pharmacist shall make a notation of such request upon the prescription blank."
- "If a nonbrand-name drug product is dispensed, the pharmacist shall include on the label of such drug product dispensed pursuant to a prescription, the established name or the name of the manufacturer, except where the prescriber indicates to the contrary on the prescription."

Rx

substitution permissible _____
do not substitute _____ (initial)

_____ MD

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription form illustrated on the preceding page. This form requires a distinct change from the way he has previously written prescriptions.

There are now *two* spaces for the prescriber's initials. The prescription will be filled generically or with another brand name of that drug unless the physician initials the space stating "do not substitute." When transmitting an oral prescription, the physician must explicitly state that there shall be no substitution. Only by taking these

measures can he ensure that the brand-name drug he prescribes will actually be dispensed.


If the physician elects to permit substitution, he must indicate this by initialing the space marked "substitution permissible." The drug actually dispensed must be of lower cost and must be contained in the latest published list of interchangeable drug products. Substitutions shall not be made unless cost savings are passed on to the consumer.

Please refer to a copy of the law for complete details.

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Maternal Deaths in New Jersey—1977

JAMES P. THOMPSON, M.D., Paterson*

Nineteen maternal deaths occurred in New Jersey in 1977. Analysis of the details of these deaths, including demographic and pathologic factors, is discussed. Pregnancy-related hypertension and hemorrhage accounted for thirteen of the deaths. A plan of action to reduce the number of maternal deaths in the future is presented.

Impetus in recent years has been directed by obstetricians toward reducing perinatal morbidity and mortality. While these efforts are laudable and seem to have proved worthwhile, maternal deaths still occur with a disconcerting frequency. The process of maternal mortality review began in New Jersey in 1932 and it is of historic interest to note that our State was the third in the nation to formulate a committee to study that problem.¹ The reduction or elimination of preventable factors encountered in the study of maternal deaths constitutes a primary goal of maternal mortality committees. Decreases in the maternal death rate in geographic areas with functioning committees have been interpreted as bearing a direct relationship to the presence of the committee.^{2,3} Recent evidence indicates that the association between these committees and the decline may be temporal as well as causal.⁴ The membership of the present committee feels that review of maternal deaths by a responsive group is imperative but that publication of the data and education of those responsible for rendering obstetric care are of equal importance.

MATERIALS AND METHODS

The Committee†, comprised of eight obstetricians selected on the basis of interest, expertise, and geographic area of practice, takes its authority from the Committee on Maternal and Child Care, a special committee to MSNJ's Council on Public Health, and is charged with the study of all maternal deaths occurring in the State and making recommendations for improving maternal health.

Identification of maternal deaths was accomplished as outlined in a previous communication.⁵ The total number of live births and the characteristics of the obstetric population were obtained from the New Jersey State Vital Statistics Office. The available medical records, including hospital charts and prenatal information, when available, were allocated to committee members for thorough review well in advance of the scheduled meeting of the whole Committee. Each record was presented and discussed prior to formulation of an opinion by the Committee as to cause of death and preventability. Patient, physician, and institutional anonymity were preserved to the utmost; following the meeting all records were returned to their source and the compilation of numerical data was all that remained.

RESULTS

There were 93,786 live births in the State in 1977 and 19 maternal deaths were identified and presented for study. Table I characterizes the obstetric population for the year of

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"The paucity of information on many of the hospital records often made a precise comment difficult but attempts were made to classify each death on the basis of information available."

"Of the classic etiologic triad of toxemia, hemorrhage, and infection, eleven of the twelve preventable deaths were ascribed to toxemia and hemorrhage."

study. Those with "unknown" prenatal care had no documented evidence of the presence or adequacy of care. Table II gives the classification and rates as suggested by the American College of Obstetricians and Gynecologists.⁶

The nineteen deaths occurred in eighteen different hospitals in all geographic areas of the State. One death occurred at home; three occurred in an emergency treatment area and the remainder in the surgical or obstetrical suite. Among the hospitalized patients, four expired undelivered, five underwent spontaneous vaginal delivery, and nine delivered via cesarean section.

Tables III and IV describe age, race, and prenatal care, and parity and gestational age. Ten of the seventeen patients eligible for prenatal care received less than adequate care. Review of the records revealed this to be due both to patient and physician factors. Eight of the patients were nulliparous.

PATHOLOGIC REVIEW

Autopsy reports were available on fourteen patients and a clinical diagnosis was assigned by the Committee to the remainder. In a number of patients, multiple factors contributed to the demise and in those without the confirmatory evidence of a postmortem study the predominant clinical complication was listed as cause of death. Table V lists the deaths due to a direct obstetric cause by pathologic diagnoses and Table VI lists the associated non-obstetric causes of death.

The aspect of preventability was the most difficult of the Committee's deliberations. The paucity of information on many of the hospital records often made a precise comment difficult but attempts were made to classify each death on the basis of information available. Table VII is a summation of the non-preventable and preventable deaths and, in the case of the latter, an assignment to contributory factors.

COMMENT

The impressive reduction in maternal mortality rates over the years has led many to believe that an "irreducible minimum" has been reached. McKelvey felt that a rate of about 20/100,000 live births appeared to be "the rational lower limit of obstetric deaths." The rate of 20.3 that occurred in New Jersey in 1977 appears to be in line with this concept but it is disturbing to reflect upon the fact that fully 63 percent of these deaths were associated with preventable factors. As long as there are preventable maternal deaths we should not speak of an irreducible minimum.

Of the classic etiologic triad of toxemia, hemorrhage, and infection, eleven of the twelve preventable deaths were ascribed to toxemia and hemorrhage. Of the seven deaths due to toxemia, four patients with eclampsia became comatose and never regained consciousness. One pre-eclamptic patient died of acute respiratory arrest after having received a total of seven grams of magnesium sulfate in six hours; one

died of a cerebrovascular hemorrhage and one of acute yellow atrophy of the liver. Of the six deaths due to hemorrhage, three had ruptured ectopic pregnancies (two tubal and one cornual); one died of an abruptio placenta with inadequate blood replacement; and one died of postpartum hemorrhage due to a retained placenta. Six of the patients developed a coagulopathy secondary to the primary process but only one patient expired of acute blood loss during intervention for a fetal death *in utero* due to the profound alteration in the clotting mechanism.

The remaining preventable deaths were due to inappropriate use of alphaprodine hydrochloride (Nisentil®), following intramuscular injection of diazepam (Valium®) leading to cardiovascular collapse, and the inability successfully to intubate a patient with status asthmaticus in the latter stages of pregnancy. It was felt by the anesthesiologist in attendance that the size of the gravid uterus coupled with delayed emptying time of the stomach in pregnancy led to aspiration of gastric contents during the repeated attempts to intubate.

The indirect obstetric deaths were due to pulmonary embolism in two patients following cesarean section; one was due to a self-administered ethchlorvynol (Placidyl®) overdose in a patient later learned to be pregnant; and the remaining death, four weeks postpartum, was due to peritonitis secondary to toxic megacolon in a patient with known Crohn's disease.

Why did these patients die?—In an attempt to assess preventability, the Committee made every effort not to be judgmental but rather to utilize informational and technical aspects as outlined in the medical records. In almost every instance it was a matter of "too little too late." In the deaths due to toxemia, dosages of magnesium sulfate were often inappropriately low. They were begun after the coma ensued and in one instance discontinued before delivery. Anti-hypertensive therapy in those patients with sustained diastolic blood pressures greater than 100 mg Hg was erratic in drug selection and included multiple agents given by multiple routes of administration and almost always included a diuretic. Treatment errors were related to the lack of a systematic and vigorous approach. In deaths due to hemorrhage, the failure to perceive the nature and extent of blood loss was evident. With the exception of the ruptured ectopic pregnancies, one of which was diagnosed pre-operatively, volume replacement was delayed and inadequate. It was encouraging to note that use of an oxytocic agent did not contribute to any of these deaths.

What can be done to decrease the number of preventable maternal deaths in the future?—It was the unanimous opinion of Committee members that the obstetric community be made aware of the number and causes of death and that intensive educational programs follow to diminish their occurrence in the future. Specific recommendations include

the following: (1) provide obstetric department chairmen with the data included in this report and request them to disseminate the information to their staff and include the material in their educational programs; (2) provide county maternal mortality committee chairmen with the same information with a similar request; (3) members of the Committee should be available to each hospital department throughout the State to go over the data in greater detail; (4) develop and integrate regional consultation and referral services into an acceptable program of continuing education; and (5) continue efforts to provide every obstetric patient access to early and adequate prenatal care.

It is hoped that this and future reviews will aid in designing and reinforcing measures which will make the delivery of an infant even less hazardous to the mother.

Table 1
Obstetric Population

Race		
	White	78%
	Black	20%
	Spanish Surname	2%
Age		
	Less than 20	13%
	20-34	81%
	35-39	5%
	More than 40	1%
Prenatal Care		
	Care	
	None	1.5%
	Inadequate	1.5%
	Unknown	8%
	Adequate	89%

Table 2
Classification and Mortality Rates

Live Births	93,786
Maternal Deaths	19
Direct	15
Indirect	4
Rate (direct only)	16/100,000 live births
Rate (indirect only)	4.3/100,000 live births
Rate (all causes)	20.3/100,000 live births

Table 3
Characteristics by Race, Age, and Prenatal Care

	Number	Percent
Race		
	White	11
	Black	7
	Spanish Surname	1
Age		
	Less than 20	2
	20-34	14
	35-39	2
	More than 40	1
Prenatal Care		
	Care	
	None	4
	Inadequate	3
	Unknown	3
	Adequate	7
	Excluded (ectopic)	2

Table 4
Parity and Duration of Pregnancy

	Number	Percent
Parity		
0	8	42%
1-3	11	58%
Gestational Age		
Less than 20 weeks	4	21%
20-28 weeks	2	10%
28-40 weeks	9	48%
More than 40 weeks	4	21%

Table 5
Pathologic Diagnoses — Direct Obstetric Deaths

Toxemia		7
Pre-eclampsia	1	
Eclampsia	4	
Cerebrovascular hemorrhage	1	
Acute yellow atrophy of liver	1	
Hemorrhage		6
Ectopic pregnancy	3	
Abruptio placenta	1	
Retained placenta	1	
Coagulopathy	1	
Miscellaneous		2
Analgesia	1	
Status asthmaticus	1	

Table 6
Pathologic Diagnoses — Indirect Obstetric Deaths

Pulmonary Embolism	2
Suicide	1
Peritonitis	1

Table 7
Preventability of Maternal Deaths

A. Indirect Causes		4
Non-preventable	4	
B. Direct Causes		15
Non-preventable	3	
Preventable	12	
1. Physician factor	8	
2. Patient factor	2	
3. Both	2	

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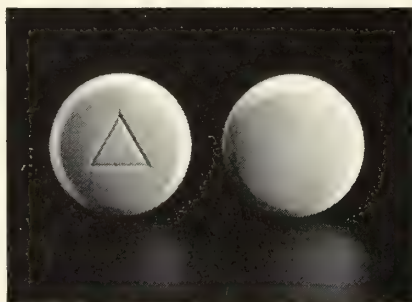
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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record of drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

The logo for the Pharmaceutical Manufacturers Association (PMA) consists of the letters 'PMA' in a bold, stylized, sans-serif font. The 'P' and 'M' are connected, and the 'A' is separate.

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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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Percutaneous Aspiration Biopsy of Abdominal and Retroperitoneal Tumors

JOHN L. NOSHER, M.D. AND JULES PLAFKER, M.D., New Brunswick*

Fine-needle aspiration is a useful technique in the diagnosis of abdominal and retroperitoneal tumors. It is a safe procedure with a high yield in diagnosing pancreatic, renal, lymphatic, and hepatic tumors.

Percutaneous aspiration biopsy is a new technique for the cytologic diagnosis of abdominal and retroperitoneal masses. It is an alternative to the diagnostic laparotomy to provide histologic diagnosis of deep-seated tumors. The procedure is safe, accurate, and economical.

The success of percutaneous aspiration biopsy depends on the use of fine needles, 22 or 23 gauge. They allow penetration of abdominal organs in the path of a tumor, without the danger of laceration or hemorrhage. The cross sectional area of a 23 gauge needle is 1/7 that of a Menghini needle and 1/14 that of a Vim-Silverman needle. Because of the small caliber of the needle, the aspiration specimen consists of isolated cells rather than a core of tissue. Finally, a system of guidance must be available that assures precise placement of the aspiration needle in the tumor mass. This most frequently is provided by ultrasound although computerized tomography, arteriography, lymphangiography, or fluoroscopy may be used.

TECHNIQUE

The patient is instructed to take nothing by mouth six hours prior to the procedure. Sedation usually is not required because the pain experienced during the procedure is minimal.

Following localization of the mass, and determination of its depth with ultrasound, the skin at the biopsy site and subcutaneous tissues are anesthetized locally. While the

patient suspends respiration, a 22 or 23 gauge Chiba needle is passed in one continuous motion, with stylet in place, into the tumor. The stylet is removed and a 10cc syringe is placed on the hub of the needle. Maximum suction is applied to the syringe, and the needle is agitated vertically several times over a one centimeter path. Suction is released and the needle is withdrawn.

The aspiration material is handled by the cytotechnologist who is in the examining room with the radiologist. The material from the syringe is sprayed onto microscope slides and smears are made similarly to peripheral blood smears. Some slides are placed immediately into 95 percent alcohol for immediate wet fixation; these slides are stained by the Papanicolaou method. Other slides are air dried and stained by the Giemsa method. The remaining aspirated material is processed as a cell block for histologic sectioning. The latter also affords the luxury of utilizing special stains when they are needed for differential diagnosis.

ILLUSTRATIVE CASE PRESENTATIONS

Case 1—A 65-year-old female presented with a six-month

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Figure 1A—Transverse supine ultrasound scan demonstrating a mass in the head and body of the pancreas (p). Also seen are the abdominal aorta (a), and right kidney (k).



Figure 1B—Celiac arteriogram, arterial phase. There is tumor encasement of the splenic (arrow), common hepatic (open arrow), and dorsal pancreatic (asterisk) arteries.

history of upper thoracic back pain, a ten pound weight loss, and an abdominal mass which, on upper gastrointestinal series, compressed the second portion of the duodenum. The mass on ultrasound examination was localized in the head and body of the pancreas, but did not encroach upon the common bile duct (Figure 1A). Celiac arteriography excluded resectability because of encasement of the splenic and hepatic arteries (Figure 1B). Aspiration performed under ultrasound guidance yielded malignant cells consistent with adenocarcinoma of the pancreas. The cells have a paucity of cytoplasm, large nuclei, and prominent nucleoli. They are seen in nests or acinar formation (Figure 1C). Radiation therapy was initiated. Follow-up reveals a slow, progressive, downhill course with osseous metastases explaining the presenting symptom of back pain.

Case 2—A 65-year-old male presented with obstructive jaundice secondary to a mass in the head of the pancreas. At surgery an apparently unresectable carcinoma was found. A cholecystojejunostomy was performed and an enlarged lymph node was submitted as a pathologic specimen. The surgical specimen revealed no evidence of malignancy. Four months later the patient developed intractable back pain. Ultrasound at this time revealed a pseudocyst in addition to



Figure 1C—Adenocarcinoma of the pancreas showing nests of malignant cells which are cohesive. (Papanicolaou stain, 45X)

a solid mass in the head of the pancreas. Palliative radiation therapy was withheld pending a tissue diagnosis of malignancy. A percutaneous aspiration biopsy was performed using a barium-filled duodenum impressed by tumor as a landmark for needle placement (Figure 2A). The specimen contained adenocarcinoma (Figure 2B). Radiation therapy was administered. The patient has undergone a slow, downhill course.

Case 3—A 57-year-old male presented with a four-month history of weight loss, back pain, leg edema, and rapidly enlarging abdominal mass. Intravenous urogram demonstrated ureteral displacement. Abdominal ultrasound suggested lymphatic origin because of multiple lobular masses with homogenous echo patterns. Aspiration biopsy produced a spectrum of cells varying from well differentiated lymphocytes to poorly differentiated lymphocytes with nucleoli, to histiocytic forms which are larger and have coarser nuclear chromatin. Cells were less cohesive than carcinoma cells. This was diagnosed as a malignant lymphoma, mixed cell type (Figure 3A). The patient responded dramatically to chemotherapy with rapid shrinking of the tumor.

Case 4—A 78-year-old male presented with weight loss and a chest radiograph demonstrating multiple nodules (Figure 4). Metastatic work-up revealed a solid renal mass (Figure 4B). An aspiration of the renal mass was performed under ultrasound guidance. The cells had enlarged hyperchromatic nuclei with coarse chromatin; some cells had irregular nucleoli. Malignant cells were seen in nests and sheets. Within the latter, some cells had clear cytoplasmic vacuoles. The diagnosis was adenocarcinoma consistent with hypernephroma (Figure 4C).



Figure 2A—Barium-filled duodenum impressed by a tumor in the head of the pancreas (arrows). Tumor occludes the air-filled common bile duct (open arrows).



Figure 2B—Adenocarcinoma of the pancreas showing nests of malignant cells. The nucleoli are prominent in some cells. (Papanicolaou stain, 45X)

DISCUSSION

Recent reports attest to the usefulness of fine needle aspiration in diagnosing the etiology of pancreatic and retroperitoneal masses.¹⁻⁵ With the exception of a 300cc, clinically insignificant hematoma³ and an exacerbation of chronic pancreatitis⁵, there have been no significant complications. There have been no false positive cases of malignancy reported.

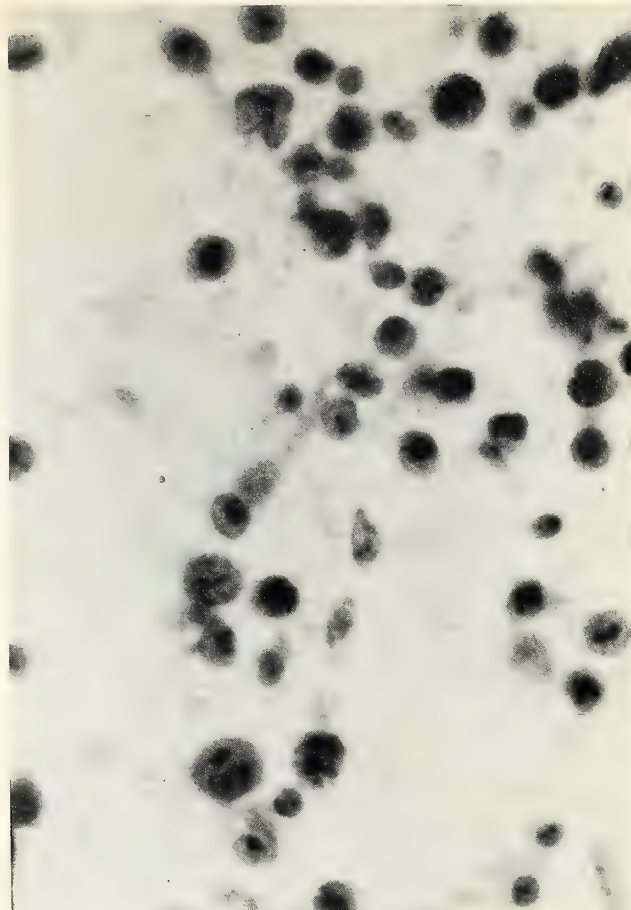


Figure 3A—Aspiration from retroperitoneal lymphoma, lympho-histiocytic type cell block. The cells are singular showing transitions from lymphoid to histiocytic forms. (Papanicolaou stain, 45X)

Tumor seeding has not proved to be a significant problem. Our experience is similar to that reported in the literature (Table 1). Our over-all accuracy has been 85 percent. Confirmation of biopsy diagnosis has been by means of surgery, autopsy, or, in most cases, clinical course consistent with the diagnosis.

The pancreas is an organ particularly suited to this diagnostic approach. Unfortunately pancreatic malignancy most often is detected at an unresectable stage. In most cases surgery offers little more than relief of biliary obstruction and histologic diagnosis. Radiation therapy in unobstructed patients yields results at least as good as surgery⁶. Angiography offers a means of predicting resectability and curability⁷, and aspiration is a way of establishing a diagnosis in surgically incurable lesions. Our accuracy in pancreatic tumor diagnosis of 77 percent compares favorably with the literature.¹⁻⁵ Failure to diagnose a tumor is related most frequently to misdirection of the needle or scirrhous lesions with inadequate cellularity for diagnosis.

Abdominal masses of lymphomatous origin are best diagnosed by aspiration when radiation therapy or chemotherapy is contemplated. We have aspirated three masses involving lymph nodes; these were malignant lymphomas, mixed cellularity, and one metastatic adenocarcinoma. The experience of the MD Anderson Hospital group⁵ indicated that metastatic tumor involving lymph nodes is diagnosed more easily than lymphomas.

Liver tumors also are well suited for aspiration biopsy with ultrasound guidance, yielding a high percentage of positive results. This is the subject of a separate detailed report.

Table 1

Organ	Malignant	Benign	Inadequate Cellularity for Diagnosis	Percent Accuracy
Pancreas	5	2	2	77%
Liver	10	2	3	75%
Lymphatic	3	0	0	100%
Renal, Adrenal	5	0	0	100%
Misc.	1	0	0	100%
Total	24	4	5	85%

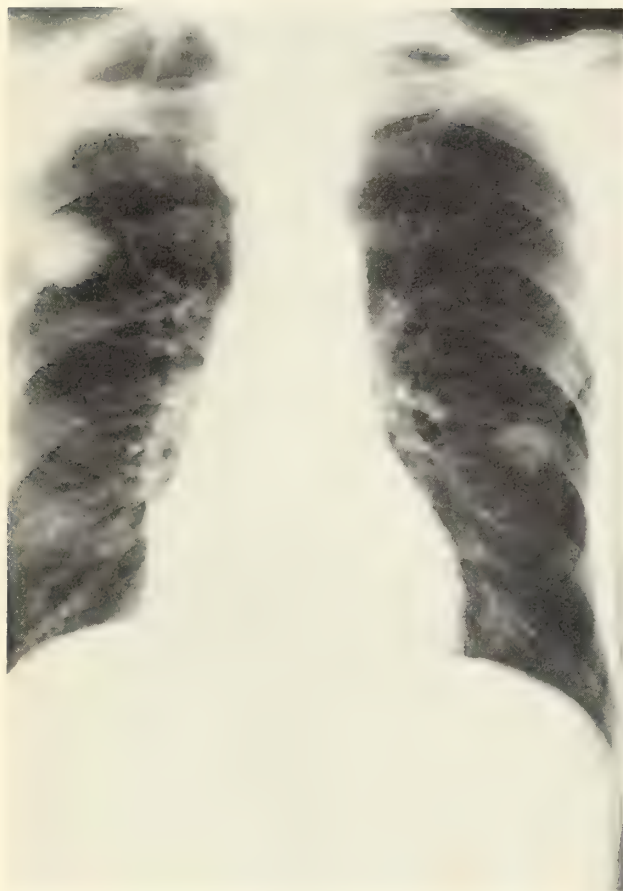


Figure 4A—PA chest radiograph demonstrating bilateral pulmonary nodules.



Figure 4B—Longitudinal prone ultrasound scan through the right kidney demonstrating a solid mass in the upper pole of the kidney (m). Also noted are the normal calyces in the lower pole of the kidney (arrow).



Figure 4C—Aspirate showing a nest of malignant cells with occasional cytoplasmic vacuoles consistent with hypernephroma. (Papanicolaou stain, 45X)

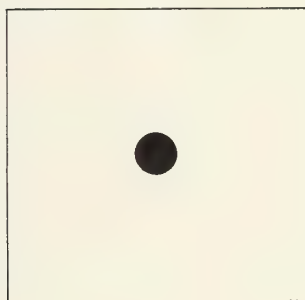
SUMMARY

We have found percutaneous aspiration with ultrasound safe and accurate. It offers an alternative to laparotomy in providing a cytologic diagnosis in deep abdominal tumors.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Ectopic Pregnancy As a Cause of Maternal Death in New Jersey

GERARD F. HANSEN, M.D., Hackensack*

A review of maternal deaths in New Jersey in 1977 due to ectopic pregnancy was made. The diagnosis and treatment of this condition was reviewed. A plea is made to include ectopic pregnancy in the differential diagnosis of lower abdominal pain in a woman in the child-bearing age.

Ectopic pregnancy continues as a major cause of maternal mortality. Of the fifteen direct obstetrical deaths in New Jersey in 1977, three were caused by intraperitoneal hemorrhage secondary to ectopic gestation. A condition causing twenty percent of maternal deaths cannot be ignored.

ETIOLOGY

The fallopian tube is the most common site of an extra-uterine pregnancy. Any interference with tubal mobility may predispose to the trapping of the fertilized ovum causing its growth and final rupture outside the uterine cavity.¹

The frequency of ectopic gestation is rising, with the true incidence probably higher than the often-quoted figure of 1:200 gestations.² This may be due in part to: (1) the rising incidence of infections that may result in a patent but scarred fallopian tube despite adequate antibiotic treatment; (2) endometriosis, a condition of the woman who defers childbirth, may cause decreased motility of the fallopian passageway; (3) abortion, as a method of pregnancy control, may cause minimal salpingitis secondary to subclinical infection following suction curettement.³

The role of the intrauterine device (IUD) as an etiologic agent has been discounted by recent epidemiological studies.⁴

While hindsight is always easy, the following two cases serve as examples of happenings in our state in 1977.

CASE 1

A twenty-one-year-old female was seen in the emergency room with a chief complaint of stomach pain, vomiting, and "blackouts" beginning on that date. Her last menstrual period was six weeks prior to the visit. She gave a history of regular twenty-eight day cycles and was not utilizing any effective form of birth control. No other significant history was noted. Vital signs showed temperature 97F, pulse 64/minute, respirations 20/minute, blood pressure 100/60. Pelvic examination disclosed abdominal tenderness and an anteverted uterus. No masses were palpable but both fornices were tender. A diagnosis of pelvic inflammatory disease (P.I.D.) was made and the patient received a prescription for propoxyphene napsylate with aceta-minophen.^a No laboratory tests were performed.

Less than twenty-four hours later the patient was returned to the emergency room by ambulance. She had no discernible pulse or blood pressure and had shallow respirations. Despite intensive resuscitation measures including laparotomy and thoracotomy she expired two hours after admission. A ruptured ectopic pregnancy was found at surgery.

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^aDarvocet N 100® (Lilly)

COMMENT

- (1) The lack of detail in the above case report is because no other information was available from the chart.
- (2) Failure to include ectopic pregnancy in the differential diagnosis was an error.
- (3) Laboratory tests might have revealed a low hemogram. A two-minute pregnancy test, if positive, would have aided in the diagnosis. This proved again more errors are committed by omission than commission.
- (4) One may wonder if the lack of a proper examining table with stirrups, good lighting, privacy, and thus the ability to do an adequate pelvic examination, including culdocentesis for non-clotting blood may be a problem in many emergency rooms in the state.
- (5) The diagnosis of "P.I.D." in the absence of fever and the failure to prescribe appropriate antibiotics with such a diagnosis are errors.
- (6) Finally, all patients should be encouraged to return for further evaluation if a condition does not improve or worsens.

CASE 2

A thirty-seven-year-old female Gravida II, Para I, was admitted to the hospital at eighteen weeks gestation because of generalized abdominal pain, and nausea and vomiting. She had a history of one previous normal vaginal delivery. A history of uterine fibroids and relative infertility was obtained.

Current Pregnancy: The patient had one visit at 14 weeks. The uterus was enlarged to the size of an 18-week gestation. The fetal heart tones (FHT) were heard with the Doptone.[®] Ultrasound study for fetal age was ordered but not done. On examination the patient was pale with a blood pressure of 110/70 and pulse 110 per minute. The abdomen was tender. Intraperitoneal bleeding was suspected but while waiting for the condition to stabilize, the patient had a cardiac arrest and expired despite extensive efforts to revive her. At laparotomy, the patient was found to have a ruptured cornual pregnancy.

COMMENT

- (1) While more difficult to diagnose, "thinking ectopic" (or cornual pregnancy) might have saved the patient by dictating prompt laparotomy.
- (2) This case again demonstrated that laparotomy is necessary, since the best way to stabilize such a patient is to stop the bleeding.
- (3) Occasionally, nausea and vomiting are diagnostic aids that are overlooked.

DIAGNOSIS AND TREATMENT

With history of lower abdominal pain associated with a missed or irregular menstrual period in a woman in the reproductive years, we must include ectopic pregnancy in the differential diagnosis. A history of pelvic inflammatory disease or relative infertility is often obtained. The patient typically may complain of a missed period followed by

vaginal spotting one to two weeks later. Lower abdominal pain is universally present and may be increased in the right or left lower quadrants. In the early stages, abdominal findings may be minimal. Pelvic examination may reveal tenderness in the adnexal region, but a tender mass is often difficult to palpate. Pain on movement of the cervix is often found.

Laboratory aids include serial hemograms, slightly elevated white blood count, and lack of evidence for urinary tract infection on urinalysis. While the routine pregnancy test is negative in approximately 50 percent, the newer radio-receptor assay (RRA) is said to be close to 100 percent positive if a pregnancy is present.⁵

At present, ultrasound is valuable if an intrauterine gestation can be seen. While an intra and extrauterine pregnancy are possible, the combination is less likely. Further resolution of ultrasound equipment may make the diagnosis of ectopic pregnancy easier.

Culdocentesis (placing a needle in the cul-de-sac) and obtaining noncoagulable blood is diagnostic of intra-peritoneal bleeding, but a "dry tap" may be due to an unruptured ectopic pregnancy.

Most gynecologists in New Jersey are proficient in the use of the laparoscope. When the diagnosis is in doubt, laparoscopy may resolve the question without the need for further surgery. This valuable technique should be used more frequently as nothing is more typical than the atypical ectopic pregnancy.

The treatment of ectopic gestation is surgical removal of the fallopian tube involved without extirpation of the ovary.

SUMMARY

Three maternal deaths in New Jersey in 1977 support the statement that ectopic pregnancy remains a problem. While the triad of abdominal pain, vaginal bleeding, and amenorrhea are important clues to the diagnosis, occasionally nausea and vomiting are a presenting sign and symptom. Failure to consider ectopic pregnancy in the differential diagnosis of abdominal pain in a woman in the reproductive age group remains the greatest diagnostic error. Early use of culdocentesis or laparoscopy is recommended. Ultra-sonic evaluation as a diagnostic tool is still in a developmental state but the finding of an easily diagnosed intrauterine pregnancy makes a coexistent extrauterine gestation less likely. Prompt laparotomy to control bleeding is important.

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Left Atrial Myxoma: Two-Dimensional Echocardiographic, Angiographic, and Pathological Correlations

ARTHUR E. MILLMAN, M.D.,
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Left atrial myxoma can be diagnosed accurately and quantitated by two-dimensional sector scanning, and left ventricular function can be evaluated. The risk of cardiac catheterization thus may be avoided.

Left atrial myxoma, a protean clinical entity,¹⁻¹⁹ has been difficult to diagnose until the advent of M mode echocardiography.²⁰⁻³³ It was demonstrated classically on A and M mode echocardiography over 15 years ago.²⁰ Hemodynamic data obtained at cardiac catheterization showed some typical features of this syndrome but also considerable variability reducing its sensitivity while preserving its specificity.^{6,11,34-39} Angiocardiology is a highly sensitive and specific technique but is also an invasive diagnostic modality and, therefore, carries with it some morbidity and mortality.⁴⁰ Left atrial myxoma has been well demonstrated on sector scanning and dynamic B scan ultrasonography.⁴¹⁻⁴² In this paper, we report a case of left atrial myxoma studied from a volumetric standpoint, echocardiographically and angiographically.

METHODS

M Mode Scan was performed with a Smith Kline Model 2022, echocardiograph unit, using a 7.5 cm focused 2.25 mega HZ transducer and recorded on Kodak rapid access paper on a 1856 Honeywell stripchart recorder. Sector scans through the long axis and short axis of the left ventricle, aortic root, and left atrium were performed in slight left lateral projection, using a Smith Kline Ekosector Scanning Unit and were recorded on video tape and Polaroid film, the latter for use in volumetric studies.

Cardiac catheterization was performed in the fasting state

with the patient premedicated with meperidine 50 mg and phenergan 25 mg, by intramuscular injection. A right antecubital vein was cannulated via a cutdown and pressures were measured in the right atrium, right ventricle, pulmonary artery, and pulmonary capillary wedge positions. A 30° right anterior oblique pulmonary angiogram was performed and a levo-phase follow through was recorded. Left ventricular volumetrics were performed, using a modification of the area length method of Dodge, *et al.*⁴³⁻⁴⁴ The tumor volume was calculated from the area and major and minor axis, assuming it to be an ellipsoid, using the same method as for ventriculography.⁴⁵ The same assumption was used for calculations from the echocardiographic Polaroid pictures.

CASE PRESENTATION

A 62-year-old female was well, with the exception of mild hypertension treated with diuretics, until January, 1977, when she gradually noted increasing dyspnea on exertion and occasional exertional retrosternal heaviness. She became unable to leave her home because of the shortness of breath and chest pain. Spontaneously, her symptoms cleared and

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she saw her physician. At that point, a heart murmur was noted for the first time. There was no history of acute rheumatic fever or congenital heart disease. The patient was treated with propranolol hydrochloride 10 mg, orally, four times a day. Over the subsequent six weeks, she developed nausea, fatigue, and anorexia. Propranolol was stopped, but no improvement in her symptoms occurred. The dyspnea returned and progressed to paroxysmal nocturnal dyspnea one month prior to her admission to the hospital. Two weeks prior to admission, she developed pedal edema. On admission to the hospital, a fever was noted up to 102° F. Cardiomegaly, a right lower lobe infiltrate, and pleural effusion were noted on chest x-ray. The patient was treated with cephazoline, 2 gm IV every six hours; a right thoracentesis was performed. Streptomycin, 500 mg IM every twelve hours, was added.

In July 1977, the patient was transferred to this hospital for further evaluation and treatment. On admission she was dyspneic at rest in a semi-Fowler's position. Body surface area was 1.66 M². Blood pressure was 110/70 mm/Hg, pulse 110/min and regular, respiratory rate was 25/min and oral temperature 99° F. Postive physical findings included hepato-jugular reflux, dullness at the right lung base and slight dullness at the left lung base, rales half-way up the chest bilaterally. There were a sinus tachycardia with a ventricular rate of 110/min. The PMI was in the sixth intercostal space at the anterior axillary line. There was a faint left ventricular lift and a prominent apical impulse was noted. There were no shocks. The first heart sound was normal. The second heart sound physiologically was split with the pulmonic component louder than the aortic component. The pulmonic component of the second heart sound was audible at the apex. A third heart sound was heard in diastole. A 111/IV musical apical systolic murmur, radiating toward the left axilla and left posterior axillary line was noted. A 11/IV decrescendo diastolic rumbling murmur was heard at the apex; it radiated to the posterior axillary line at the fifth intercostal space. The liver was 5 cm below the right costal margin and slightly tender. Two plus pitting pretibial edema was present. Blood and urine cultures were negative. The antibiotic regimen was continued and the patient became afebrile and remained so. Digoxin® 0.25 mg daily, Lasix® 120 mg daily, and potassium chloride were prescribed. The patient's congestive failure diminished. The electrocardiogram showed non-specific ST and T wave abnormalities. The SMA-12 showed a mildly elevated LDH. The hematocrit was 31.9%, hemoglobin 10.1 gm/dl and the white blood cell count 9,400/mm³ with a normal differential. The serology, latex fixation, and urinalysis were negative. The erythrocyte sedimentation rate was 120 mm per hour. An M echocardiogram, a sector scan with long axis and short axis views, and a phonocardiogram with carotid pulse tracing, apex cardiogram, and systolic time intervals were performed. The patient was referred for surgery.

RESULTS

Phonocardiogram, carotid pulse tracing, apex cardiogram, and systolic time intervals were compatible with a mobile left ventricular inflow obstruction, such as left atrial myxoma. There was a prominent presystolic wave on the carotid pulse tracing and a prominent notch on the early systolic rise of the apex cardiogram.^{37,47} The M mode scan demonstrated a large mass of disordered echoes, posterior to the anterior leaflet of the mitral valve and prolapsing with ventricular systole into the left atrium (see figure 1).

Left atrial size was increased moderately (50 mm). Left ventricular function was normal. (Left ventricular end systolic diameter 27 mm and end diastolic diameter 43, ejection fraction 68%.)

Pulmonary valve tracing demonstrated diminished "A" dip of one mm, EF slope of eight mm/sec, and opening velocity of 300 mm/sec suggest pulmonary hypertension. The sector scan demonstrated a spheroidal mass prolapsing from the left atrium to the left ventricle in atrial systole, and showed similar findings on both long axis and short axis views. Left ventricular function appeared normal. The mass was 43 cc in volume assuming it to be an ellipsoid and using the Dodge biplane area length method⁴⁵ (see figures 2 and 3).

Cardiac catheterization demonstrated the following pressures:

Right atrial mean pressure:	5 mm/Hg A wave = 10 mm/Hg
Right ventricular pressure:	76 systolic, 7 diastolic end diastolic = 10 mm/Hg
Pulmonary artery pressure:	76 systolic, 30 diastolic mean = 45 mm/Hg
Pulmonary capillary wedge mean pressure:	40 mm/Hg with an A wave of 38 and V wave of 40 mm/Hg.

The pulmonary artery cineangiogram showed slightly dilated pulmonary arteries and a slightly enlarged left atrium. There was a lobular mass attached by a pedicle to the inferior aspect of the inter-atrial septum, prolapsing through the mitral valve into the left ventricle in atrial systole. The mass had an intrinsic rocking or twisting motion as it moved. The mitral valve appeared normal as did the left ventricle (see figure 4).

The left ventricular end diastolic volume index was 53 cc/m², subtracting the tumor volume. The left ventricular end systolic volume index was 22 cc/m². Left ventricular stroke volume index was 31 ml/m², subtracting the tumor volume, with an ejection fraction of 73 percent (59 percent for tumor volume). The tumor volume was 45 cc corresponding closely with the volume calculated from the biplane sector scan. Angiographic cardiac output was 10.2 L/min, uncorrected for the tumor mass and 5.5 L/min with an index of 3.3 L/min/M² with the tumor volume subtracted from the stroke volume.

OPERATIVE FINDINGS

The patient was placed on cardiopulmonary bypass after

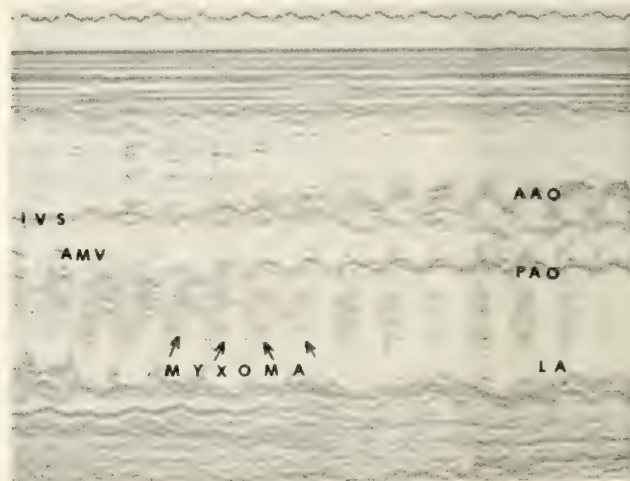


Figure 1—M mode echo scan from aortic root to left ventricle demonstrating a disorganized cloud of echoes representing the left atrial myxoma. A small posterior pericardial effusion is also present.

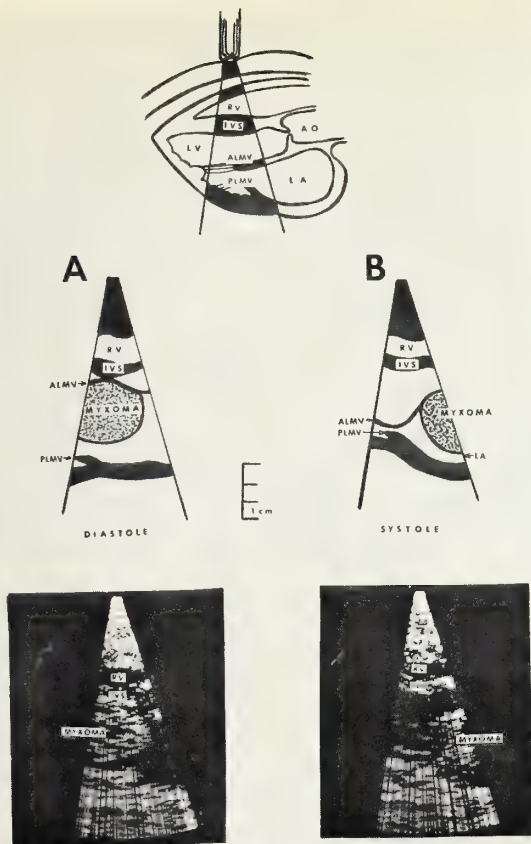


Figure 2—Schematic representation and stop-action photograph of long axis sector scan of the left atrial myxoma in systole and diastole. The spherical nature of the myxoma can be appreciated. (Ao = Aorta, RV = Right Ventricle, IVS = Interventricular Septum, LA = Left Atrium, LV = Left Ventricle, ALMV = Anterior Leaflet of the Mitral Valve, PLMV = Posterior Leaflet of the Mitral Valve)

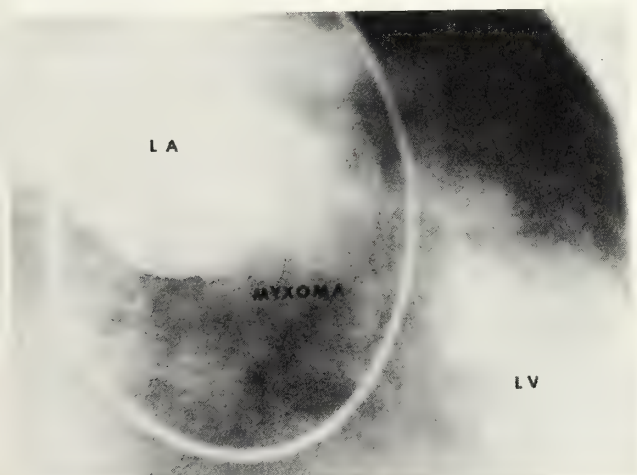


Figure 4—Levophase frame from pulmonary cineangiogram in the right anterior oblique projection. The tumor is a globular mass prolapsing from the left atrium to the left ventricle. (LA = Left Atrium, LV = Left Ventricle)

cardioplegic and hypothermic arrest. The inter-atrial septum was incised posterior to the attachment of the tumor. The tumor was extremely friable and large portions of it had to be removed by suction. The base of the tumor was excised down to the coronary sinus. The mitral valve leaflets were thickened slightly but were flexible and of full volume so there was no necessity for replacement of the mitral valve. A 3 x 4 cm surgical defect in the inter-atrial septum was closed with a dacron patch. There was transient AV dissociation, then first-degree heart block, and a permanent epicardial suture-

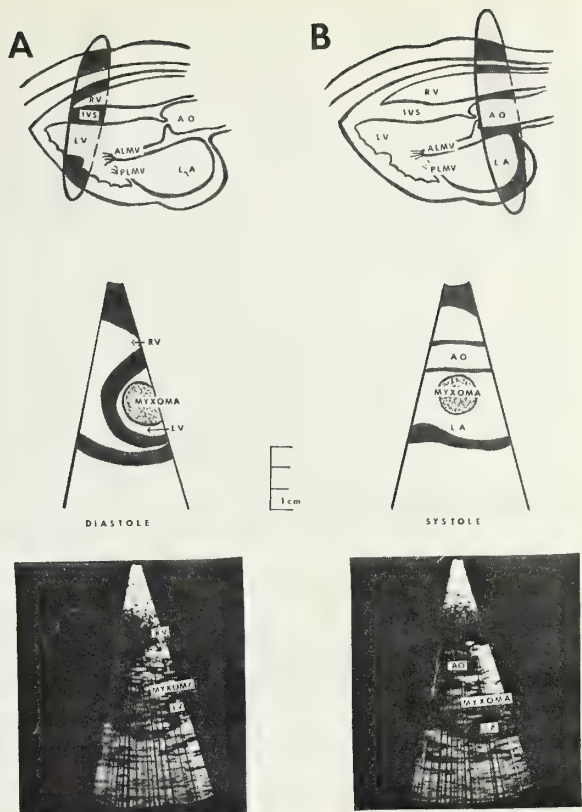


Figure 3—Schematic representation and stop-action photograph of short axis sector scan of the left atrial myxoma in systole and diastole. The spherical nature of the myxoma is now seen in a second plane, 90° from the long axis plan. (Ao = Aorta, RV = Right Ventricle, IVS = Interventricular Septum, LA = Left Atrium, LV = Left Ventricle, ALMV = Anterior Leaflet of the Mitral Valve, PLMV = Posterior Leaflet of the Mitral Valve)

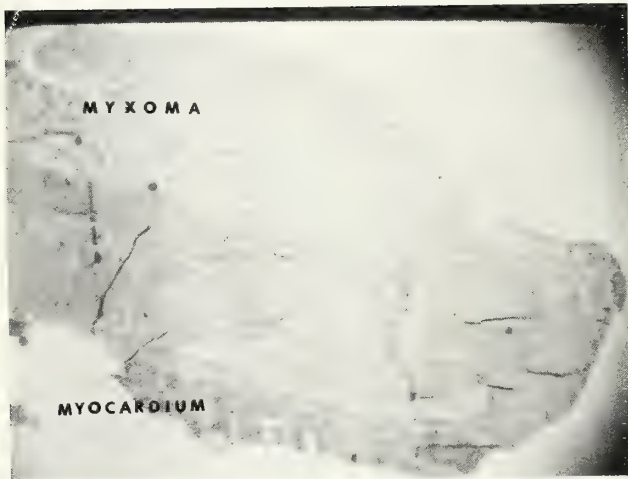


Figure 5—Photomicrograph of surgical specimen demonstrating the myxoma, myocardial interface. The mucinous nature of the myxoma is apparent. (Hematoxylin and Eosin stain, magnification of 40 X)

less electrode was inserted and placed in a left pectoral subcutaneous pocket for possible future pacing needs. Post-operative pressures demonstrated a V wave on the left atrial trace and the mean left atrial pressure remained 16 to 18 mm/Hg.

PATHOLOGICAL FINDINGS

There was a large gelatinous mass arising from a broad base on the left atrial aspect of the inter-atrial septum. The lower portion of the mass extended to within one cm of the

"Left atrial myxoma is diagnosed easily by standard M mode echocardiography except when the mass is superior and lamellated^a rather than pendunculated.⁵²"

"Accurate tumor volumetrics and evaluation of left ventricular function can be obtained non-invasively through sector scanning, at no risk to the patient."

mitral valve and the myxomatous tissue was densely adherent to the valve.

On histologic section, the tumor mass consisted of a myxoid and partially mucinous tumor with scattered cords of bland endothelial cells. There were occasional pools of mucin. This was histologically consistent with a myxoma (see Figure 5).

DISCUSSION

Left atrial myxoma is diagnosed easily by standard M mode echocardiography except when the mass is superior and lamellated^a rather than pendunculated.⁵²

The friability of these tumors, as illustrated in our patient, makes left-sided invasive studies somewhat hazardous. The extent and location of the tumor cannot be predicted always accurately from the M mode echocardiogram.^{33,47} In addition, tumors may extend across the inter-atrial septum and be bilateral.^{20,49}

Two-dimensional echocardiography or sector scanning allows demonstration of the inter-atrial septum, permitting visualization of bilateral tumors. In addition, the larger field and simultaneous presentation of landmark structures, on the sector scanner, permit accurate localization of masses in all four cardiac chambers.

The volumetric analysis of the tumor by two-dimensional, essentially biplane, technique compares favorably with the single-plane angiographic estimates and, also, with the clinical impression of the surgeon at the time of operation. The friability of the tumor prevented "en-bloc" resection and formal volume measurements of the gross specimen. The anatomic and volumetric analysis of myxomata and ventricular function by sector scanning in two planes is helpful in pre-operative evaluation and may obviate the need for invasive studies, which may reduce the patient morbidity and mortality.

Several studies have demonstrated that atrial myxomas may recur and also may be seen in kindred members of the propositus.^{48,51} The patient's blood relatives are being evaluated with echocardiography and serial echocardiographic studies on the patient will be performed.

SUMMARY

A 62-year-old patient with atrial myxoma was studied by M mode echocardiography, two-dimensional sector scanning, and angiography; volumetric correlations were made. Operative findings indicated a high risk of embolization from the tumor reemphasizing the risks of instrumentation of the left atrium and/or left ventricle prior to surgery. Accurate tumor volumetrics and evaluation of left ventricular function can be obtained non-invasively through sector scanning, at no risk to the patient.

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Left Atrial Myxoma Without Significant Cardiac Manifestations

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Most patients with atrial myxoma present with a composite of cardiac and non-cardiac, nonspecific protean symptoms and signs. A case of an elderly male with a left atrial myxoma with a non-cardiac presentation and course is described. The pertinent literature is reviewed.

In 1951, Prichard¹ reviewed tumors of the heart and noted that myxoma of the atrium never had been diagnosed antemortem. In the 28 years since, numerous case reports of antemortem diagnoses by echocardiography and angiocardiology and surgical correction have appeared in the literature. Yet the diagnosis still is missed often and Goodwin,² in his review, stressed that "probably the most important single factor in making the diagnosis is awareness of the condition and the ways in which it may present." The non-cardiac manifestations of left atrial myxoma have been stressed by Goodwin² and others³⁻⁷ and Morgan *et al.*⁸ described a patient with an atrial myxoma who presented without cardiac manifestations. We report here a patient with a left atrial myxoma who had no specific cardiac manifestations until his terminal 12 hours.

CASE REPORT

A 79-year-old male was evaluated in the office because of one month of generalized weakness. He had surgery for a carcinoma of the prostate in 1974 and was maintained on Tace[®] 12 mg. daily. In 1975 he had a pulmonary embolus and had been maintained on Coumadin[®] without complication. Nine months previously his weight was 172 lbs. at a routine annual examination. Hemoglobin was 14.5 gms/dl, and sedimentation rate was 11 mm/hr. Examination was negative except for weight loss to 162 lbs. and pallor.

Laboratory review revealed the hemoglobin to be 10.5

gms/dl; urinalysis, stool tests for occult blood, and Coombs test were negative. B-12 and folic acid levels were normal. Coumadin[®] was discontinued and hospitalization was advised but the patient refused. A few days later he was seen again; his cardiac rhythm was atrial flutter with variable block. Digoxin 0.25 mgm. was prescribed daily and hospitalization again was recommended. The patient did not agree to hospital care for another month by which time he was extremely weak.

On admission, his pulse was 80 regular, BP 108/50, R 14, T 98.6. He was pale but there were no petechiae or nailbed clubbing. The head and neck were negative; no lymph node enlargement was found. Neck veins were flat and lungs were clear. The heart percussed to the fifth ICS at the MCL. A normally split S2 and normal S1 were heard. A Grade I/VI apical midsystolic murmur was present without an opening snap, rub, gallop, or diastolic murmur. The abdomen, extremities, and neurological examination were normal.

Laboratory data: WBC 7,500 with normal differential; Hgb. 10.3 gms/dl, Hct. 30.7%, MCV 79u³, MCH 26.1 mg., MCHC 33.3%, Retic. 2.4%. ESR was not obtained. Red cell morphology was normal; haptoglobin was 252 mg/dl, SMA-12 was normal except alkaline phosphatase of 139 u,

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acid phosphatase 0.36 units, serum Fe 19 mgm/dl, TIBC 189 mgm/dl, Urinalysis was negative. Stool guaiac tests were negative, EKG showed atrial flutter with 4:1 block (figure 1). Chest x-ray was normal (figure 2).

A search for occult neoplasm was unsuccessful with negative barium enema, upper gastrointestinal series, bone scan, and sigmoidoscopy. The patient was felt to have an iron deficiency anemia secondary to nutritional causes and he was discharged on multivitamins with vitamin C, ferrous gluconate, digoxin 0.25 daily, and Tace® 12 mg. daily.

The patient was readmitted 16 days later after slipping to the floor at home. It was not clear whether he had fainted. Physical examination was unchanged from the previous admission. The heart still showed atrial flutter with variable block and the mid-systolic apical murmur was the same. The lungs were clear, the liver was not enlarged, and there was no peripheral edema.

Laboratory data revealed Hct. 33.8%, Hgb. 11.5 gms.%,

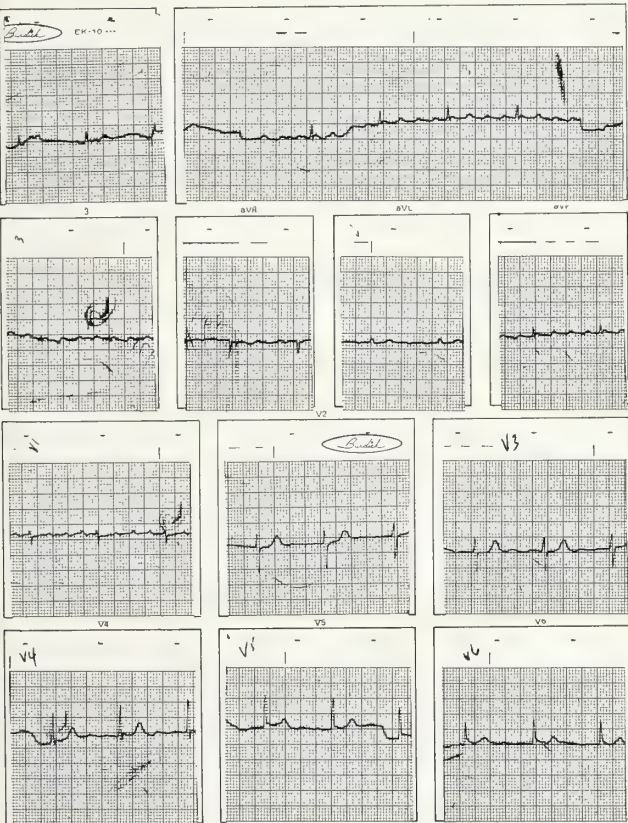


Figure 1—Electrocardiogram (first admission) eight weeks before death.

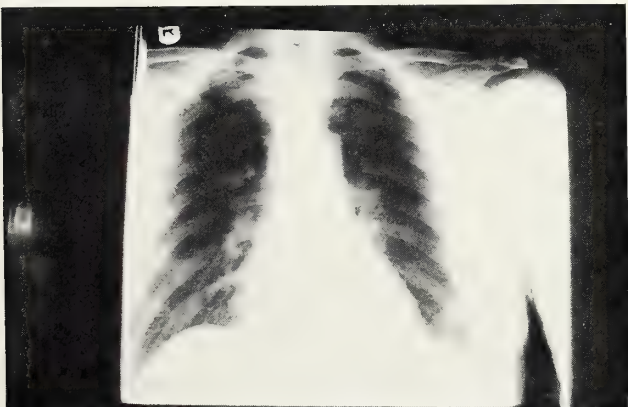


Figure 2—Chest x-ray (first admission) eight weeks before death.

WBC 11,900, 80 polys, 12 lymphs, 6 bands, 1 mono, 1 eos. Urinalysis was normal. SMA-12 was normal except LDH 250, SGOT 120, alkaline phosphatase 190, acid phosphatase .30; serum protein electrophoresis revealed albumin 2.5 gms/dl (43.1%) but was otherwise normal. Chest x-ray and electrocardiogram were unchanged from previously. Lung scan showed several segmental perfusion defects at the left lung base consistent with, but not diagnostic of, pulmonary emboli. Bone scan was negative; liver scan showed normal size with homogeneous distribution. Percutaneous liver biopsy showed a nonspecific hepatitis.

The initial hospital course during the evaluation described was uneventful. The patient was afebrile and his murmur was unchanged. The EKG switched from atrial flutter to atrial fibrillation. There were no syncopal episodes although he was ambulatory but very weak. On the morning of the patient's final day he was found to be in pulmonary edema. A preterminal chest x-ray (figure 3) confirmed this and was markedly changed from all his previous chest films (figure 2). He failed to respond to diuretics, sedation, and oxygen and expired nine hours later.

At autopsy the heart weighed 420 gms. and the valves were normal. Arising from the lower interatrial septum was a myxoma which measured 8.0 x 5.5 x 2.8 cm. (figure 4) and was smooth on all surfaces. There were no areas of irregularity suggestive of sources of emboli. The lungs did not show areas of infarction. The liver showed only passive congestion.

DISCUSSION

Atrial myxoma, the commonest primary cardiac tumor, comprises almost half of all such tumors; 75 percent of them

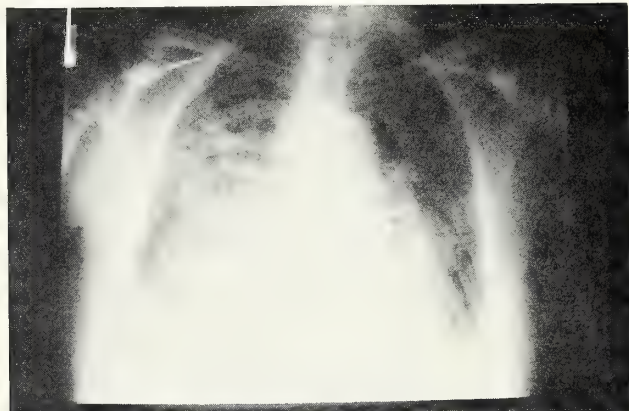


Figure 3—Chest x-ray (second admission) eight hours before death.



Figure 4—Pathological specimen at autopsy.

"Atrial myxoma, the commonest primary cardiac tumor, comprises almost half of all such tumors; 75 percent of them arise from the left atrium, usually at the fossa ovalis¹."

"The constitutional symptoms are not well understood but have been ascribed to toxins released from tumor breakdown and multiple tiny emboli."

arise from the left atrium, usually at the fossa ovalis¹. They are most common between 30 and 60 years of age but have been described in newborns and patients 80 years old; they are more common in women⁹.

The multiple clinical manifestations have been described several times^{2-5,9}. In his reviews, Goodwin divides the manifestations into obstructive, embolic, and constitutional.

The obstructive effects are the result of partial and intermittent occlusion of the mitral valve orifice by the tumor. This results in primarily a diastolic murmur which is similar to mitral stenosis but is often more apparent in the erect position⁵. A mitral regurgitant murmur also can be present due to distortion of the valve mechanism during closure. Dizziness or syncope have been emphasized as prominent symptoms, but Wight found it in only three of his 10 patients⁵ and Greenwood in only 11 of 45². Pulmonary hypertension with secondary right ventricular hypertrophy may occur.

Embolic complications result from tumor emboli and are often multiple. Surgical removal of the embolus or muscle biopsy done for suspected peripheral vasculitis may show the myxomatous nature of the thrombus on pathological study and lead to the correct diagnoses¹⁰. Pulmonary arterial emboli occur in right atrial myxoma but paradoxically are more common in left³. This probably is related to the low cardiac output, venous stasis and thrombus formation in peripheral veins in left atrial myxoma.

The constitutional symptoms are not well understood but have been ascribed to toxins released from tumor breakdown and multiple tiny emboli. Currey *et al.*¹⁰ found antibodies to heart muscle which decreased after removal of a right atrial myxoma. They suggest that an autoimmune state may contribute to the systemic reaction. Hepatic dysfunction due to heart failure and low cardiac output also may play a role. These manifestations include low-grade fever, fatigue, anorexia, weight loss, elevated erythrocyte sedimentation rate, increased gamma globulin, anemia, leukocytosis, and thrombocytopenia².

The chest x-ray may be normal or simulate mitral stenosis with enlarged left atrium and appendage, pulmonary trunk, venous engorgement, Kerley B lines, and right ventricular enlargement. Calcium deposits in the tumor can occur and appear as non-valvular, intracardiac calcifications¹¹.

Cardiac arrhythmias are relatively frequent with atrial fibrillation and flutter most common. Paroxysmal atrial tachycardia and conduction disturbances have been noted¹¹.

Goodwin² reviewed the cardiac and non-cardiac manifestations of atrial myxoma and concluded that the most valuable clues to clinical diagnoses are combinations of obstructive, embolic, and constitutional features. In his review of 40 patients, 31 had at least one obstructive with at least one constitutional feature; 34 had effort dyspnea or

pulmonary hypertension or mitral murmurs and 26 had all three. In 1974, Morgan⁸ described a 35-year-old female whose myxoma was not diagnosed antemortem because there were no cardiac features. The disease presented with arthralgias and myalgias and evaluation suggested a collagen disease. She finally succumbed to a cerebral tumor embolus. Huston⁷ reported a case of left atrial myxoma which simulated peripheral vasculitis. Later in the patient's course a diagnostic murmur was heard which led to an echocardiographic study. The diagnosis then was established with discovery of the characteristic multiple abnormal echoes below the anterior mitral leaflet. A retrospective review of a gastrocnemius muscle biopsy specimen taken earlier showed myxomatous material making up emboli in the visible arteries.

Prior to 1968 the definitive diagnostic procedure was pulmonary angiography which delineated the atrial mass. In 1968, Slattenburg first described the diagnosis of left atrial myxoma by echocardiography¹². This technique has been utilized many times since and makes the diagnosis easier to establish and may lead to curative surgery. Of course, to order echocardiography one has to have a high index of suspicion of the possible diagnosis.

Our patient's cardiac manifestations were minimal and nonspecific consisting of a nondiagnostic, mid-systolic hemic murmur and atrial fibrillation. The incident of falling which prompted the second admission may have been a syncopal episode, but even the family was not aware of unconsciousness. It was not until 12 hours before death that obstructive findings and pulmonary edema developed. The main features of our patient's illness were weakness and severe anemia. The low serum iron and normal haptoglobins led to a diagnosis of probable iron deficiency anemia which was considered nutritional once gastrointestinal blood loss was excluded. In retrospect, the iron deficiency anemia may have been secondary to chronic hemolysis with renal losses of iron as has been described following the insertion of prosthetic aortic valves. However, this is highly speculative since there were no histiocytes described on smear and the hemolysis in aortic valve prosthesis is thought to be secondary to rapid flow over the mechanical valve. The atrium is a low flow chamber unless the bulk of the tumor could have mechanically damaged the red cells causing increased hemolysis. Initially, the progressive hepatic dysfunction was thought to be secondary to occult neoplasm but the homogeneous liver scan and nonspecific biopsy excluded this diagnosis—but not in time to lead to the correct diagnosis antemortem.

The terminal pulmonary edema almost certainly was due to the myxoma flopping into the mitral valve orifice causing mechanical obstruction to blood flow. This explains the lack of response to diuretics, oxygen, and sedation.

“Cardiac arrhythmias are relatively frequent with atrial fibrillation and flutter most common. Paroxysmal atrial tachycardia and conduction disturbances have been noted¹¹.”

“In 1968, Slattenburg first described the diagnosis of left atrial myxoma by echocardiography¹². This technique has been utilized many times since and makes the diagnosis easier to establish and may lead to curative surgery.”

SUMMARY

Echocardiography has simplified the antemortem diagnosis of left atrial myxoma, greatly increasing the frequency of surgical cure. Nevertheless, the diagnosis remains difficult in that the disease presents with protean manifestations. Although 75 percent of patients have cardiac and constitutional findings, some patients present only with constitutional symptoms or with constitutional features and minimal cardiac signs. In this situation, echocardiography may not be ordered and the diagnosis missed. One such patient is discussed and the pertinent literature reviewed. It is hoped that this knowledge will facilitate earlier diagnosis in the future.

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Echocardiographic Diagnosis of a Pseudotumor of the Left Ventricle: A Calcified Posterior Papillary Muscle

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An enlarged calcified posterior papillary muscle mimicked a mobile left ventricular tumor. The pseudotumor was diagnosed by echocardiography and confirmed by cardiac angiography and cineradiography. At surgery, a large calcified posterior papillary muscle which fixed the posterior chordae tendinae of the mitral valve was found.

Only six reports of left ventricular tumor or thrombus diagnosis by echocardiography are noted in the literature.¹⁻⁶ This paper describes a patient's echocardiographic findings that differ from those reported and mimic a mobile tumor of the posterior papillary muscle.

Echocardiography was performed in a semi-erect supine position using a 13 mm in diameter 2.25 MHz transducer with a 7.5 cm internal focus. Permanent recordings were made on a Honeywell 1858 strip chart recorder which was interfaced to a Unirad Sonograf II system.

Cineradiographic motion studies were made on a Tagarno recorder. Right- and left-sided cardiac catheterization and left ventricular angiographic studies were performed in the usual way.

CASE HISTORY

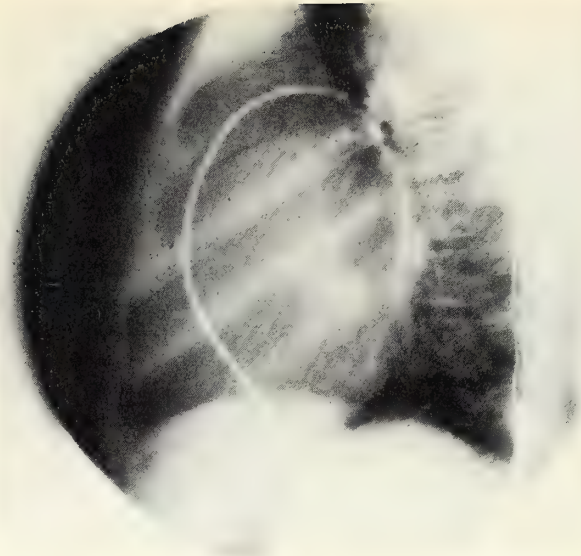
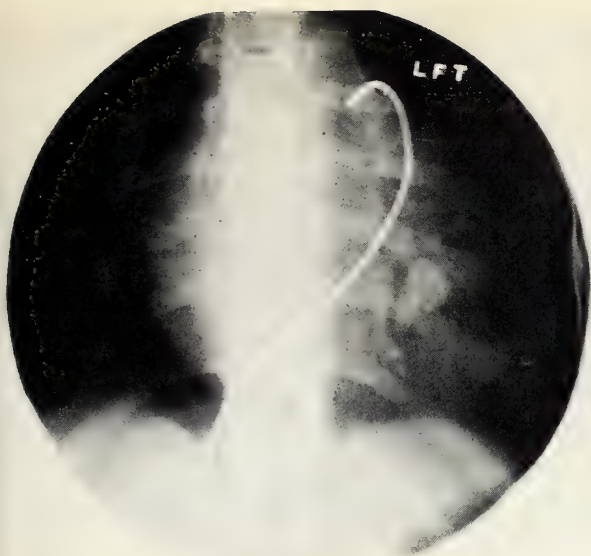
This child was born after a normal pregnancy and delivery and was considered to be in good health. She received little or no medical supervision until five years of age, when she was admitted to the hospital because of fever, cough, dyspnea, and hemoptysis. Chest roentgenograms revealed marked cardiomegaly and central pulmonary vascular congestion. She was treated with antibiotics and digoxin, and improved. The diagnosis of congenital mitral insufficiency was made after cardiac catheterization. From age six to ten years, outpatient cardiac examinations revealed physical findings compatible with congenital mitral regurgitation,

roentgenographic findings of marked left atrial and left ventricular enlargement, and electrocardiographic evidence of left atrial and biventricular enlargement. She complained of exertional fatigue and dyspnea, and continued to take digoxin and intermittent diuretics. At 12 years of age, because of increasing symptoms, poor appetite, weakness, and the finding on chest roentgenogram of a calcific mass in the left heart (Figures 1 A, B), she underwent echocardiography and cardiovascular catheterization.

Echocardiography disclosed a prominent echo-reflective mass inferior to the area of the mitral valve. This mass could not be separated from the posterior left ventricular wall (Figure 2). It exhibited a distinct anteroposterior motion that varied with the cardiac cycle. Also noted were a decreased mitral valve E to F slope, paradoxical motion of the posterior mitral leaflet, and a giant left atrium.

Findings at cardiac catheterization revealed mitral insufficiency and stenosis with mild pulmonary hypertension. Angiocardiography revealed a pear-shaped calcified mass in the body of the left ventricle immediately below the mitral valve, moving synchronously (Figure 3 A) with the ven-

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Figures 1A and 1B—Plain radiographs AP and Lateral views respectively demonstrate a two cm calcification in the midposterior aspect of the left ventricle.

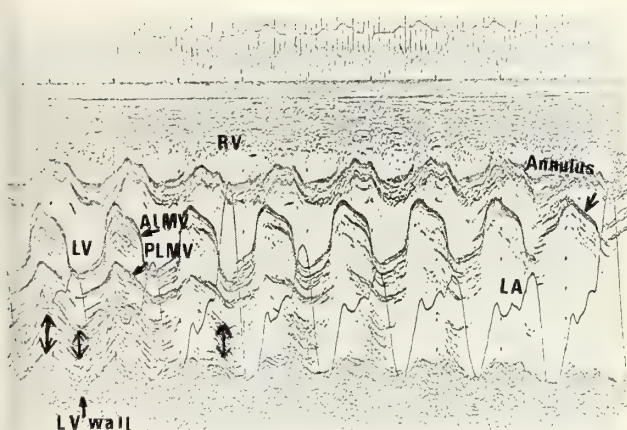


Figure 2—Echocardiogram showing a sweep from the body of the left ventricle into the left atrium at the level of the mitral annulus. A mass of mobile echoes below the paradoxically moving posterior mitral valve leaflet (PLMV) is demonstrated attached to the posterior left ventricular wall.

ricular wall. There was no impairment or dyskinesia of left ventricular contraction. A giant left atrium secondary to mitral insufficiency was noted (Figure 3 B).

At age 12 years, 2 months the left atrium was explored under hypothermia and cardiopulmonary bypass. The atrium was enlarged greatly and a jet lesion was seen on its posterior wall. The mitral valve was thickened and there was prolapse of the anterior leaflet. The posterior papillary muscle was thickened to twice its normal size and an area of

calcification was noted at its attachment to the left ventricle and extending into the posterior wall of the left ventricle. The appearance of the lesion suggested healed infection superimposed on a congenitally abnormal posterior papillary muscle and mitral valve. A biopsy of the papillary muscle revealed only fibrosis. The operative procedure consisted of dividing the posterior papillary muscle in its midportion down to its attachment to the left ventricle. The chordae of the anterior leaflet were shortened, and the mitral valve annulus was reduced by plication. Postoperatively the patient's symptoms were improved slightly, and she still required an intensive cardiotonic regimen.

DISCUSSION

The echocardiographic findings of a mobile mass inseparable from the posterior papillary muscle are unique on review of the world literature. Farooki *et al.*¹ described two cases of ventricular rhabdomyoma in infants. One occurred in the left ventricle and was identified by an abnormal cluster of echoes adjacent to the left side of the interventricular septum (IVS). Similar findings of a left ventricular thrombus were described by Horgan *et al.*² and by Levisman *et al.*³ The latter study also noted a cluster of echoes with the left ventricular cavity between the mitral valve and the IVS during systole caused by a pedunculated left ventricular thrombus. Finally, Orsmond *et al.* described a similar situation in a patient with left ventricular alveolar rhabdomyosarcoma which also appeared between the mitral valve and the IVS; somewhat more extensive involvement

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“The echocardiographic findings of a mobile mass inseparable from the posterior papillary muscle are unique on review of the world literature.”

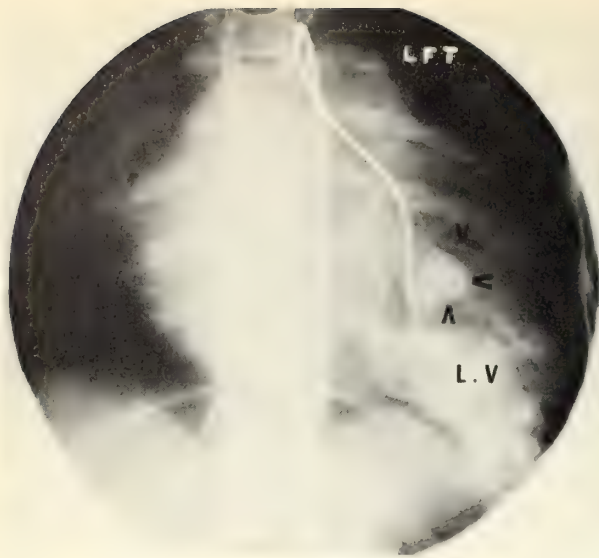


Figure 3A—Left ventricular angiogram demonstrates radiolucent defect with a central calcification suggesting a mass lesion.

was noted in the left ventricular outflow tract clearly obstructing the aortic valve.⁴ An almost identical description was reported by Yabel *et al.* secondary to a left ventricular fibroma in a neonate.⁵ De Joseph *et al.* reported a left ventricular thrombus at the apex of the left ventricle with amorphous dense echoes below the level of the mitral leaflets lying between the IVS and the left ventricular wall posteriorly and clearly separated from these structures.⁶ This thrombus did not exhibit motion.

SUMMARY

In five of the six previous reports of left ventricular mass described by echocardiography, the diagnosis essentially was made by a mass of echoes anterior to the mitral valve closely related to the interventricular septum. The fifth case, although posterior to the mitral valve, was clearly in the apex of the heart and dissimilar to the pseudotumor motion pattern exhibited in our case.

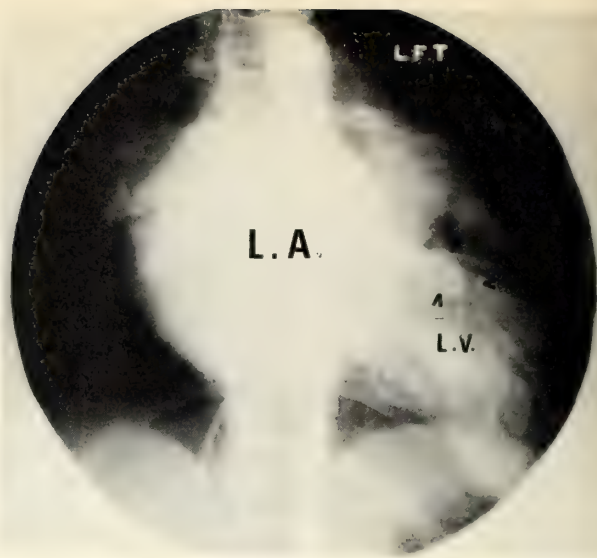


Figure 3B—Left ventriculogram (LV) showing severe mitral regurgitation into a giant left atrium (LA). The arrowheads outline the calcified posterior papillary muscle.

The etiology of the calcified papillary muscle in our patient was idiopathic, but an antecedent localized infarction, traumatic episode, or infection is postulated.

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Stress Testing

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Stress testing with ECG monitoring is a widely used technique for the documentation of the anginal syndrome and as a test of the patient's cardiac reserve. It usually is performed on a treadmill or bicycle according to a fixed protocol. The patient exercises to a theoretical maximal (or sub-maximal) heart rate or until significant ECG changes or symptoms of chest pain, dyspnea, or extreme fatigue appear. Additional end points are a fall in blood pressure and the development of cardiac arrhythmias. Both a physician and nurse continuously must monitor the ECG and blood pressure.

Stress testing also can be performed by the 2-step Master technique. Though not as accurate as the treadmill or bicycle stress test it is an effective screening device and requires less equipment and personnel. The end points are similar.

CASE 1

A hypertensive 54-year-old male developed left chest pain. The pain was located over the apex of the heart, was burning in nature, and could be brought on by exercise but often came on at rest. The pain usually lasted two to ten minutes but often could be aborted in one to two minutes by sublingual nitroglycerin.

Physical examination: the blood pressure was 170/106 mm Hg. The point of maximal impulse was just beyond the MCL in the 5th intercostal space. The 2nd sound was accentuated at the base. A grade II/VI ejection systolic murmur was audible in the 2nd intercostal space on the left. The lungs were clear to auscultation and percussion. There were no signs of congestive heart failure.

The routine 12-lead electrocardiogram showed increased

voltage and non-specific S-T depression and T wave inversion in L1, aVL, V5 and V6. A stress test was performed and was within normal limits (see figure 1).

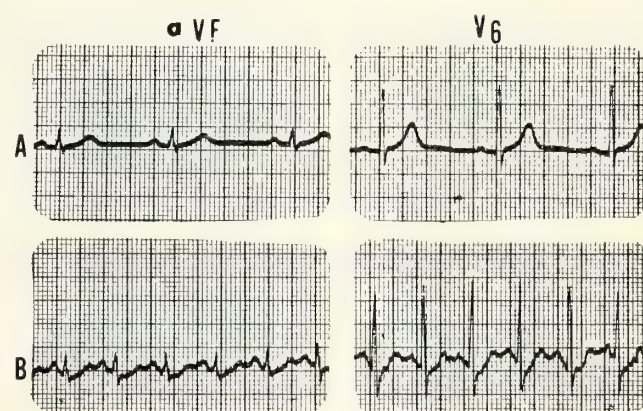


Figure 1(A)—Resting leads aVF and V6 show regular sinus rhythm at a rate of 60 beats/min. and normal configuration of S-T and T.

Figure 1(B)—The patient had a pulse rate of 144 beats/min. after exercising for two minutes at 2.0 mph on the three percent grade. There is J depression of one to two mm but the S-T segment rises obliquely to a normal upright T wave. At 0.08 sec. the S-T segment is isoelectric. The patient remained symptom-free. The test is considered normal.

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CASE 2

The patient was a 61-year-old male without prior cardiac history. Approximately six months prior to the present test he developed left-sided chest pain not related to exertion or motion. The pain was stabbing in character and would last from a few minutes to a half hour. It was not relieved by nitroglycerin. The 12-lead resting ECG was within normal limits. An exercise stress test was performed at the request of the patient who was extremely apprehensive (figure 2). The stress test was positive and confirmed the diagnosis of angina pectoris secondary to coronary artery disease.

DISCUSSION

The normal response to exercise reveals S-T segment depression of less than one mm. Another normal response to exercise is seen in figure 1. In this patient the exercise ECG reveals J point depression with a rising S-T segment. The S-T segment is continuously rising and at 0.08 sec. after the S wave is at the isoelectric line.

A positive stress test is based on a characteristic S-T abnormality. The S-T is depressed more than one mm; it remains horizontal or descending for 0.08 sec. or more. The greater the S-T depression, the more significant the change and the more certain the diagnosis. In case two the S-T depression of four mm was highly significant even though there was a one mm depression prior to the exercise test. The associated chest pain relieved by nitroglycerin is further evidence for ischemic heart disease.

Although the exercise stress test yielded clear-cut positive and negative results in these two patients, such is not always the case. A positive test is not always due to coronary artery disease nor does a negative test exclude it. Nevertheless when combined with a careful clinical evaluation the test does yield important diagnostic information. The greater the S-T seg-

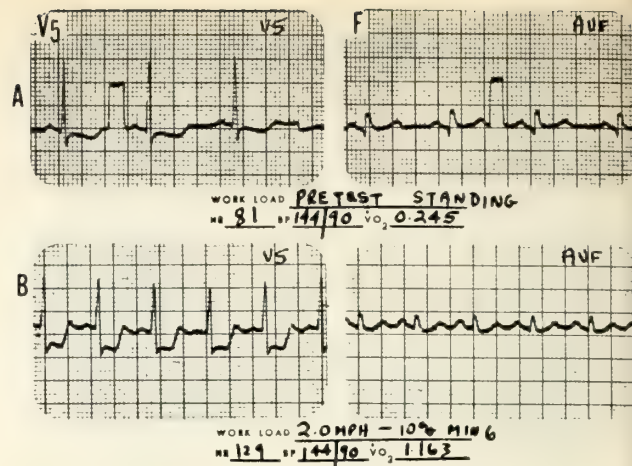


Figure 2—Row A shows V5 and aVF prior to the start of the test. In V5 there is a one mm depression of the S-T segment followed by a negative T wave. The S-T segment and T waves are normal in aVF. The heart rate is 81 beats/min.

Row B is the electrocardiogram recorded during exercise at the time that the patient developed his characteristic chest pain. His heart rate was 129 beats/min. V5 now shows S-T depression of four mm which is horizontal and slightly downward in direction. The T now has a terminal upward deflection. In aVF the S-T and T are relatively unchanged. The patient was given sublingual nitroglycerin; the pain abated and the electrocardiogram reverted to control form. The test was positive.

ment depression the more probable is the presence of clinical disease. Further diagnostic help can be obtained by the concurrent use of an exercise thallium scan. The accuracy of the test is increased by stressing the patient to the maximum predicted heart rate. An increase in R wave voltage has also been reported to correlate with the presence of significant coronary artery disease.

This information is compiled by the Schwartz Inter-National
Pharmaceutic and Therapeutic Drug Information Center of the
Brooklyn College of Pharmacy, Long Island University.*

1. Do you have any information concerning the use of stanozolol in the treatment of Raynaud's phenomenon?

Raynaud's phenomenon may be idiopathic (Raynaud's disease) or associated with occlusive arterial disease and progressive systemic sclerosis.^{1,2} Therapy is primarily palliative involving either direct vasodilation or blockade of normal sympathetic nervous system activity. A number of drugs have been used to treat severe Raynaud's phenomenon but, unfortunately, controlled studies are not available to document their efficacy.¹⁻³

Stanozolol (sold as Winstrol®) is an anabolic steroid utilized to treat aplastic anemia and osteoporosis.⁴ It has been shown to enhance blood fibrinolytic activity, a property which may be of value in improving blood flow in Raynaud's phenomenon.⁵

Jarret *et al.*⁶ conducted a clinical trial to determine the effects of stanozolol on fibrinolytic enhancement in 20 patients with advanced Raynaud's phenomenon. All patients were given five mg of the drug twice daily for three months. The overall results indicated that stanozolol caused a highly significant increase in hand blood flow which persisted for at least three months after discontinuation of drug treatment. The second course of therapy increased the hand blood flow to a greater extent than the first. The persistent improvement in blood flow after treatment with stanozolol suggested that the drug also reduced the deposition of intravascular fibrin and increased the rate of lysis of preexisting fibrin clots. Side effects reported during the study included tiredness, minor fluid retention, amenorrhea, acne, and slight facial hirsutism.

In conclusion, stanozolol may be effective in the treatment of Raynaud's phenomenon. Further long-term controlled clinical studies are required to establish the efficacy of this agent in such conditions.

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2. Do you have any information on a new gold compound for the treatment of arthritis?

Currently, there are two gold compounds available for the treatment of rheumatoid arthritis—aurothioglucose (sold as Solganal®) and gold sodium thiomalate (sold as Myochrysine®), both of which are administered intramuscularly at weekly or less frequent intervals.^{1,2} The usefulness of chrysotherapy is limited by toxicity—25 to 50 percent of those treated exhibit a range of adverse reactions, including pruritis, glomerulonephritis, leukopenia, thrombocytopenia, and lesions of the mucocutaneous membranes.³

During the early 1970's, a series of gold compounds complexed with trialkylphosphines were investigated and the orally active agent auranofin was found to be the most promising. The drug presently is undergoing Phase III clinical trials for the treatment of rheumatoid arthritis.⁴

Auranofin, while closely related to aurothioglucose, contains 29 percent elemental gold compared to 50 percent for the latter. It appears that its therapeutic effect is achieved at one-third the serum-gold level of the injectables.⁵ This new agent also shows a different pattern of distribution and binding to serum proteins compared to the presently available gold compounds, and was effective when dosed orally on a twice daily schedule.^{6,7} However, human pharmacokinetic studies indicated auranofin's half-life to range from 10 to 173 days, which is extremely long and may complicate dosage recommendations.⁸

Pharmacological properties of auranofin resulting in its anti-inflammatory activity include the inhibition of antibody production (IGg), lysosomal enzyme release, and mediator release.⁹ Auranofin also appears to have a unique activity at the cellular membrane level.¹⁰ It is believed that its effect on IGg may be its most important property against rheumatoid arthritis.⁹

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chariman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, M.S., Pharm D.; T.H. Chin, Pharm. D., R.J. Fuentes, R. Ph.

Preliminary studies on the safety and efficacy of auranofin have been good, with diarrhea being the most commonly recurring side effect. Present studies are evaluating the drug's effects on body organs that might occur from the accumulation of gold. Barring no unforeseen complications, the commercial availability of this agent may be during 1981-1982.

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3. Why has clofibrate been banned from West Germany?

On January 15, 1979, the West German government removed clofibrate (sold as Atromid®) from its domestic market following a series of adverse reports over a period of ten years.¹⁻⁷ Studies indicate that clofibrate induces gallbladder diseases, is lithogenic, and produces an elevation of biliary cholesterol saturation; the cause-effect relationship is unclear.¹⁻³

The Coronary Drug Project (CDP), conducted to investigate the efficacy of cholesterol-lowering drugs in long-term therapy of coronary heart disease, retrospectively found a higher incidence of gallbladder diseases in patients who received clofibrate.⁴ Cooper *et al*⁵ also found a doubling of cholecystectomies in those subjects treated with clofibrate from their segment of the CDP.

Krasano *et al*⁶ indicated the frequency of gallbladder

diseases in their clofibrate-treated patients was similar to the placebo-control group in the CDP. Since the populations differed in respect to atherosclerotic heart disease (ASHD), they theorized that the combination of ASHD and clofibrate was responsible for the increased incidence of gallbladder diseases.

A ten-year study was coordinated by the World Health Organization to investigate the relationship, if any, between hypercholesterolemia and coronary heart disease. It revealed that clofibrate-treated patients suffered a greater incidence of gallbladder, liver, and intestinal disease than placebo-controlled groups, and underwent a three-fold increase in cholecystectomies.^{7,8}

The predominant theory of enhanced gallbladder disease related to clofibrate therapy is that altered disposition of cholesterol from body pools to excretion sites causes a change in sterol and bile acid ratios, and/or a direct toxic effect of the drug itself.⁹

The FDA's Endocrinological and Metabolic Advisory Committee held hearings considering the issuance of new warning statements in the drug's official labeling and restrictions concerning its use.

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Vitamin C and the Common Cold*

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The idea that an increased intake of vitamin C may be helpful in fighting the common cold has been around since at least the 1930's but it was not until 1970 that the publication of Linus Pauling's best seller, "Vitamin C and the Common Cold," turned the issue into a public controversy¹. Fortunately, as a result of the interest generated by this controversy, a number of scientifically sound experimental studies have been carried out and although there are still questions that remain unanswered, it is now clear that vitamin C is, unfortunately, no panacea for colds or other respiratory infections.

However, even if the promise of virtual eradication of the common cold (suggested as a possibility at one point in Linus Pauling's book) has proved to be unrealistic, there remains enough intriguing evidence of some interaction between this vitamin and the infectious process to suggest that it is worth investigating further and that it may have a role, however limited, in reducing the burden of this relatively trivial but annoying affliction.

PREVENTION OR TREATMENT?

In trying to unravel some of the confusion and conflicting evidence over the use of vitamin C in upper-respiratory infections, it is helpful to recognize that its use has been suggested either to prevent the disease from occurring or to treat it once it has occurred. These are two quite different approaches and carry with them different practical implications. Thus, if vitamin C is to be used prophylactically in an effort to prevent the common cold, not only is one faced with the problem of compliance (many people will not be bothered with taking regular medication when free of symptoms) but also with an increased possibility of side effects since these are more likely to occur with something that is taken regularly for months or years than with something that is used only occasionally and briefly as a treatment.

Similarly, two other issues of which individuals often lose sight in the rhetoric are the questions of effective dose and the basic nutritional status of the population. Thus, if a daily intake of 1000 mg of vitamin C is found to produce a beneficial effect it is important to establish whether the same effect could be achieved with a much smaller dose since undesirable side effects are more likely from large doses than small ones. Further, whatever size dose is taken, it is only likely to show an effect in a population that has room for

improvement—in other words, well-nourished individuals are likely to be poor experimental subjects for demonstrating an effect of supplemental vitamin C.

So far, few of the experimental studies that have been carried out have shown much change in preventive effect from the regular intake of large doses of vitamin C. Even where there seems to have been some effect, it is probably maximal at intakes producing "saturation." In normal healthy subjects, this is achieved at about 100-150 mg of vitamin C daily but the amount needed may be considerably increased by acute or chronic illness and at times of environmental stress. Examples of the latter are extreme cold and physical exertion and it is of interest that two of the few positive studies on regular intake of vitamin C have involved people in these circumstances: one involving students at a ski school in the Swiss mountains², the other involving Canadian Army troops in Arctic exercises.³

In relatively affluent urban subjects, it has been difficult to demonstrate much benefit from the consumption of gram quantities of vitamin C either on a prophylactic or therapeutic basis. Recent studies have been reviewed by Chalmers⁴ and Dykes.⁵

In our own studies in Toronto, we found little effect from the purely prophylactic regimens with no evidence of gradient in effect across the dosage range of 250, 1000 or 2000 mg per day.⁶ Indeed, the only impressive differences that we have seen in our experimental groups have been with a combination of prophylactic and therapeutic regimens.^{6,7} Even in these groups there was little or no evidence of an effect on the frequency of colds, upon their total duration or upon local (nasal) symptoms. Rather, the effect seemed to be restricted to the severity of the cold as measured by the amount of time spent off work or confined to the house.

The *therapeutic* value of vitamin C in large doses has received strong, anecdotal support. For example, Irwin Stone has claimed that over 95 percent of colds can be aborted by the prompt administration of approximately 1.5 g of vitamin C every half hour for three or four doses.⁹ If some individuals really have experienced this sort of re-

*Reprinted with permission of *Contemporary Nutrition* 3:10 (October) 1978, a newsletter from the Nutrition Department of General Mills, Inc. Minneapolis. Dr. Anderson is Professor of Epidemiology, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada.

sponse, then one must consider the possibility that there is a subgroup of the population for whom vitamin C is effective; whereas, for the remainder, it is relatively (or completely) ineffective since large-scale controlled trials have been quite unimpressive.^{10,11}

In summary, one may attempt to reconcile the conflicting evidence by suggesting that increased intake of vitamin C on a regular basis or at the time of illness may exert a slight beneficial effect, more marked when the two regimens are combined. The size of the effect probably varies between individuals—with many being relatively insensitive—and it also will vary according to basic nutritional status, general state of health and exposure to environmental or other stress.

MECHANISM

Some investigators have concluded that although there may be a slight effect of vitamin C on the common cold, it is too small to be of any practical value and the subject is, therefore, not worth pursuing. But this may be somewhat short-sighted since it is possible that if we fully understood the mechanism involved in producing even a slight effect, we might be able to develop it further and produce effects that were quantitatively more worthwhile. As it is, very little is known about the mechanisms that might be involved in interactions between vitamin C, the common cold and a number of other disease processes.¹²

Some have suggested that there may be a type of antibiotic effect in which high concentrations of ascorbic acid have a specific anti-viral or anti-bacterial effect. Human experiments have not lent much support to this belief although if it were true, one would expect to see variation in effectiveness depending on the type of virus or bacterium causing the illness and such variation might help to explain some of the conflicting results obtained in vitamin C trials.

Another possibility is that vitamin C has a type of antihistamine effect and although there is some experimental evidence to support this view, in our studies we saw little evidence of a reduction in nasal irritation or stuffiness.

A third possibility and one that I find the most credible is that any effect of vitamin C is via the host resistance to infection. This would be consistent with animal experiments that have shown an improved resistance to stress and with our own experience of a reduction in general constitutional symptoms ("malaise"). It would also be consistent with the high concentration of vitamin C normally found in the adrenal cortex and its depletion at times of stress.

TOXICITY

There have been virtually no documented instances of serious toxic reactions to vitamin C even when used in very large doses. This is not altogether suprising since it is a substance essential for life and one to which we and our ancestors have been exposed for millions of years. However, it is well to remember that none of our ancestors could have been exposed to the quantities that are now easily available as a result of the production of the pure substance and although it is a very simple molecule (similar to glucose), it is a strong reducing substance, an acid, and is biologically

very potent. Therefore, it is important to be cautious in its use.

There are a number of different ways, in theory at least, in which undesirable effects might occur. First, as an acid, large doses could precipitate acid stones in the urine and as a reducing substance, vitamin C could interfere with some of the common diabetic urine tests. Second, in susceptible individuals, it could have unusual metabolic effects (a greatly increased output of oxalate is one that has been identified), which are extremely difficult to detect since they may be too rare to be recognized even in large-scale studies. Third, a potentially harmful reaction is the withdrawal effect on blood levels when cutting back after prolonged intake of large doses. Blood levels of the ascorbation reach a plateau ("saturation") at an intake of 100-150 mg per day and the intake of even several thousand milligrams a day does not greatly change this plateau level. However, if after a few weeks on high intake the extra intake is stopped, blood levels can drop well below normal for several days. Whether this has any physiological significance is not known but it is possible that if it occurred at the same time as a serious illness (for example, on admission to a hospital with a heart attack), it could handicap the body's attempts to deal with the extra stress.

SUMMARY

Carefully controlled experimental studies have failed to support claims that the intake of large doses of vitamin C will prevent or cure the majority of colds. However, an increased regular intake or a large therapeutic dose at the time of illness may have a small beneficial effect and this effect appears to be on severity rather than frequency or total duration of colds. The magnitude of the effect probably varies between individuals, in different environments, and possibly according to the type of infecting agent. The use of very high doses of vitamin C might be harmful to some individuals, particularly if the intake is prolonged. However, for most people, a modest increase in the regular daily intake or brief episodes of high intake are unlikely to cause harm and may improve resistance to other types of illness, not only the common cold.

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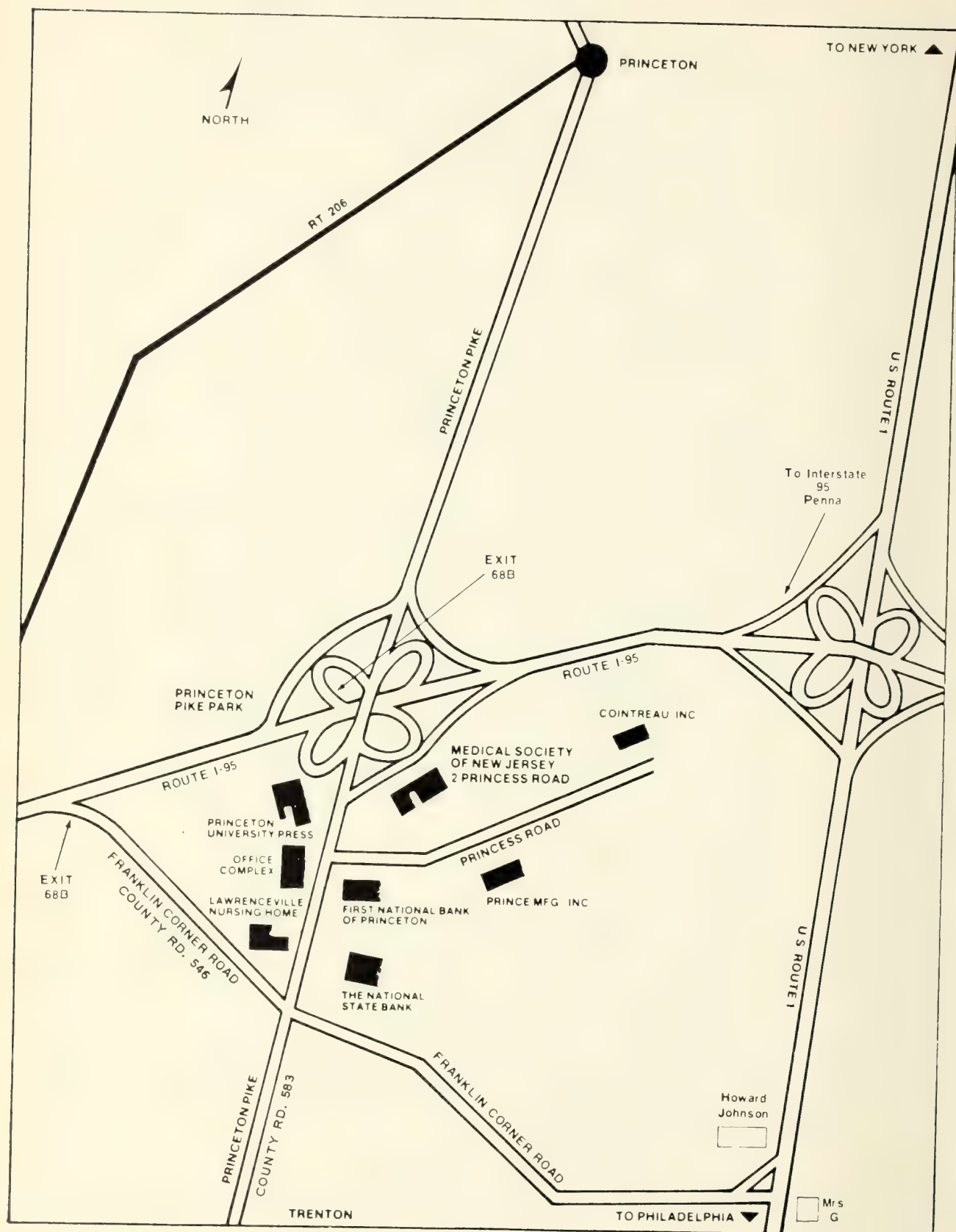
Help for Impaired Physicians

Through its Committee on Impaired Physicians, MSNJ helps doctors who are suffering from alcoholism, other drug addiction, psychiatric disorders, or senility. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early and family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

HELP US TO HELP

Call the Physicians' Confidential Assistance Line (609-896-1884). Only specially trained personnel will answer or return your call.

Area Map—MSNJ Headquarters



Trustees' Minutes August 8, 1979

A regular meeting of the Board of Trustees was held at the Executive Offices in Lawrenceville on Wednesday, August 8, 1979. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Amphetamines and Sympathomimetic Amines . . . Noted that the Board of Medical Examiners has made some changes in the regulations on the use of amphetamines (rule 13:35-6.16) and the Executive Committee had decided not to pursue the issues called for in Resolutions #31 and #33 (see p. 615, August 1979 JMSNJ), which had been referred to that Committee by the Board on May 15. President Alessi was of the opinion that a response should be presented to the House of Delegates at the fall session.

Relationship between Board of Trustees and State Board of Medical Examiners . . . Directed that the matter of review of relationships between the Board of Trustees and the State Board of Medical Examiners be pursued and that it be referred to the Committee on Long Range Planning and Development for inclusion in the study being conducted on the organizational structure of the Society.

Up-To-Date Information on Drug Incompatibility . . . Empowered the President to appoint an ad hoc committee to work in consultation with individuals in the field of pharmacology to develop a format for providing up-to-date information concerning drug incompatibility, to be presented to the State Board of Medical Examiners.

Note: The Board of Medical Examiners has agreed to accept any proposals MSNJ might wish to present.

Excessive Fees for Professional Services . . . Noted that MSNJ's judicial

mechanism is handling excessive fee complaints, however, the Board of Trustees will have the opportunity for discussion should the State Board of Medical Examiners issue regulations on fees.

MSNJ Representative at Board of Medical Examiners' Meetings . . . Agreed to continue assigning a Trustee, on a rotating basis, to attend the monthly meetings of the State Board of Medical Examiners, and directed that the President-Elect be designated also to represent the Society on a permanent basis.

. . . Directed the Executive Director to assign a member of the staff to attend Board of Medical Examiners' meetings in an advisory capacity.

Composition of House of Delegates . . . Referred the matters of student, resident, and specialty society representation in the House of Delegates and the unwieldy size of the current House of Delegates to the Committee on Long Range Planning and Development.

. . . Directed that the Committee on Long Range Planning and Development in collaboration with the Committee on Revision of Constitution and Bylaws, report recommendations (in a format appropriate for presentation to the House of Delegates) to the Board of Trustees on September 16, 1979.

Massachusetts Medical Society Program on Regulation of Laboratories . . . Received a report from President Alessi which called attention to the Massachusetts Medical Society's immediate-action program to correct medical laboratory tests with an excessive error rate whereby the Massachusetts Medical Society immediately will set up an intensive corrective program for any specific medical laboratory test with an error rate over 8 percent; the item will be referred to the Council on Public Health for discussion.

Membership Survey . . . Concurred with the Executive Committee in authorizing

MSNJ's participation in a research project on membership attitudes to be conducted by the American Society of Association Executives and authorized the expenditure of \$3,700 to participate.

Freehold Area Hospital Staff Litigation . . . Agreed with the concept that the medical staff of a hospital has the right to elect its officers and authorized financial support, in the amount of \$3,500, in the litigation of Allan W. Robbins, M.D., against the hospital. *No funds will be distributed until comments are received from the Monmouth County Medical Society and the medical staff of the hospital involved.*

Note: According to the bylaws of the Freehold Area Hospital, election of officers of the medical staff is subject to approval by the hospital board of trustees. In the event an election is not approved reasons must be given therefor and the physician involved must be granted a hearing. Allan W. Robbins, M.D., was elected Vice President of the Medical Staff. The hospital will not recognize Doctor Robbins' election, will not give reasons for disapproval, and will not grant a hearing. The matter has come to litigation and the court is considering ordering a due process hearing. The Board of Trustees of MSNJ noted that the county society has had no input in the case and deemed it appropriate for one of the Trustees to meet with the Monmouth County Medical Society and the medical staff of the Freehold Area Hospital to determine if unusual factors exist and report to the Board within one month.

. . . Directed that the county medical societies and the presidents of medical staffs of all New Jersey hospitals be advised that the proper procedure when problems arise between members of the hospital staff and the hospital board of trustees would include discussion with the county society and the hospital medical staff before the State Society enters into the discussion.

Annual Meeting—1980 . . . Noted that the Committee on Annual Meeting, with the approval of the Executive Committee, has established May 3 to 6 and the Park Place and Penthouse Hotels in Atlantic City as the dates and location of the 1980 annual meeting.

New Jersey Interprofessional Council . . . Agreed that it would not be of value for MSNJ to join the New Jersey Interprofessional Council, and voted to support the concept that professionals should stand together and agreed to work with the Council when issues of the group and MSNJ parallel.

Financial Statements . . . Accepted the report of the Executive Director on the Statements of Revenue and Expenses and Comparison of Actual Expenses to Budget for 12 months ending May 31, 1979, which were supplied to and reviewed by the Board.

CMDNJ Report . . . Received a report from Stanley S. Bergen, Jr., M.D., President of CMDNJ, which noted that:

1. Richard C. Reynolds, M.D., has been appointed as full-time Dean of Rutgers Medical School.

2. CMDNJ has been granted a five-year accreditation by the Middle States Association of Colleges and Schools.

3. Tuition will be increased for 1979-1980 by 12-1/2 percent for the medical and dental students.

4. Research programs were supported by externally-funded grants totaling \$14,000,000; sources for the funding were DHEW Institutes of Health, DHEW Health Resources Administration, DHEW Alcohol, Drug Abuse, and Mental Health Administration, and the State of New Jersey.

5. Advisory Graduate Medical Education Council has announced awards in family practice programs at St. Mary Hospital (Hoboken), West Jersey Hospital System, Overlook/Warren Hospitals, and Muhlenberg Hospital.

6. The Foundation-CMDNJ is an independent, privately-funded organization whose resources are intended and used, not to replace but to complement the State's obligatory support for medical education throughout New Jersey. It grants funds for special time-limited projects and does not assume ongoing support such as that needed to run a medical school department.

7. Concerning a Department of Family Practice, the Programs and Policy Committee of the New Jersey Medical School was directed to seek input from

the Academy of Family Physicians before submitting a final report. Currently all three medical schools of CMDNJ sponsor activities geared to stimulate interest in primary care. New Jersey Medical School's family practice activity is centered in the Office of Primary Health Care Education. A preceptorship in primary care is offered and the School is affiliated with the family practice residency programs at Mountainside Hospital in Montclair and St. Mary Hospital in Hoboken. Rutgers Medical School initiated a Department of Family Medicine in 1972 and the Department of Internal Medicine stresses primary care. RMS is affiliated with family practice residencies at Hunterdon Medical Center, Somerset Hospital, and the John F. Kennedy Medical Center. The Department of Family Medicine at New Jersey School of Osteopathic Medicine has been geared to stimulate the most interest possible in careers in family medicine.

8. Approval has been granted for construction of an underground facility adjacent to the College Hospital to house a linear accelerator and related equipment as part of the cancer research and treatment center concept.

9. The committee of consultants to review CMDNJ's admissions' policies gave the College an overwhelming positive report, and called the procedures worthy of being a national model.

MSNJ Student Association . . . Received a report from the MSNJ Student Association which noted that its membership is 237, that New Jersey medical students were well represented at the AMA Student Business Section in Chicago, and that MSNJSA will be sponsoring a series of distinguished lectures throughout the coming school year.

Bioptic Lens . . . Approved the following recommendation from the Council on Legislation, to which Resolution #30 (Bioptic Lens) had been referred (p. 617, August 1979 JMSNJ):

That legislation be proposed that would prohibit the use of telescopic lens for driving or granting a driver's license to any person requiring a telescopic lens.

Legislation . . . Approved the Council on Legislation's position on the following bills of medical import, except as noted:

S-3095—Gagliano—Emergency Medical Services—Provides that the Legislature shall review any regulations adopted by the State

Department of Health on the regionalization of emergency medical services and that said regulations may not take effect until 120 days after their submission to the Legislature. **APPROVED**

S-3096—Skevin—DES Related Disorders—Requires the State Department of Health to establish screening programs to locate, diagnose, and refer to proper treatment those who were adversely exposed to DES. The State Department of Health is to file a report with the Legislature one year from the enactment of this legislation. **APPROVED**

S-3106—Hirkala—Immunity of Review Committees—This bill extends immunities currently applicable to utilization review committees to medical audit, tissue, mortality, and peer-review committees of hospitals and long-term care facilities. This legislation is desirable. **S-777**, however, which also covers state, county, and other professional societies is much more broad and superior to this version. **ACTIVE SUPPORT**

S-3126—Parker—Workmen's Compensation—Increases physician witness fees in Workmen's Compensation hearings from \$50 to \$300 and from \$150 to \$900 in the aggregate. **APPROVED**

S-3166—Russo—Motor Vehicles—Requires the Division of Motor Vehicles to have a space on the operator's license to indicate that he suffers from diabetes. **CONDITIONAL APPROVAL**, pending an amendment to include all other potential disabling medical conditions and any other pertinent major-medical information.

S-3176—Scardino—Emergency Medical Services (M.I.C.U.)—Extends the Mobile Intensive Care Unit program until December 31, 1979. **APPROVED**

S-3198—Yates—Health Insurance—Calls for the inclusion of orthomolecular treatment under health insurance contracts with the exception of groups when the treatment is prescribed by a licensed physician. **ACTIVE OPPOSITION**, because the treatment is unscientific and because existing regulations already permit reimbursement under general medical treatment where such treatment is valid.

S-3199—Yates—Health Insurance—Same as S-3198 except it is applicable to group policies. **ACTIVE OPPOSITION**, because the treatment is unscientific and because existing regulations already permit reimbursement under general medical treatment where such treatment is valid.

S-3202 Yates—Health Insurance—Same as S-3198 and S-3199 except it applies to medical service plans. **ACTIVE OPPOSITION**, because the treatment is unscientific and because existing regulations already permit reimbursement under general medical treatment where such treatment is valid.

S-3210 Hagedorn—Licensing of Nurse-Midwives—This proposal would restrict the future licensing of midwives to only those applicants who would qualify as "nurse-midwives." Licensing would be through the State Board of Medical Examiners. Permitted acts would be: To prescribe the standards of practice of nurse-midwives under the supervision of a licensed physician.

(1) Such standards shall provide, but not be limited to, that nurse-midwives shall be permitted to:

(a) Assess the woman's social, medical and obstetrical history;

(b) Perform the initial physical assessment

and obstetrical evaluation;

(c) Order and evaluate standard laboratory diagnostic studies or tests including, but not limited to, CBC, urinalysis, serologic test for syphilis, blood type and Rh factor, sicklelex, rubella screening, papanicolaou smear, G.C. culture, T.B. screening, pregnancy test, PPD, anemia work-up, glucose tolerance test, thyroid profile, fetal status, chest x-ray, EKG, Rh antibody, cervical culture, throat culture, placental culture, nitrazine paper test for diagnosis of rupture of membranes, and such other laboratory diagnostic studies or tests as determined by the committee;

(d) Order nonprescription medication;

(e) Order prescription medication in accordance with approved orders of a licensed physician or upon the consultation and written prescription of a licensed physician;

(f) Provide counseling and teaching appropriate to the needs of the woman, newborn and family;

(g) Refer the woman to appropriate health and social agencies as indicated;

(h) Perform episiotomies and repair a perineal, vaginal or cervical laceration;

(i) Administer local or pudendal anesthesia during the performance of episiotomies and repairing lacerations;

(j) Provide family planning modalities including insertion and removal of IUDs;

(k) Practice nurse-midwifery in hospitals, medical clinics and other related health care facilities, including birthing centers; and

(l) Decide when and if a licensed physician should examine a woman who is under the nurse-midwife's management and care.

(2) Such standards shall provide, but not be limited to, that nurse-midwives shall:

(a) Practice nurse-midwifery under the supervision of and in consultation with a licensed physician who has current practice or training in obstetrics; and

(b) Immediately report or refer to a licensed physician any woman with any medical or obstetrical problem or any woman with complications or deviations from normal in childbirth. **CONDITIONAL APPROVAL**, pending deletion of repair of cervical lacerations and insertion and removal of IUDs.

Note: THIS BILL HAS BEEN WITHDRAWN BY THE SPONSOR.

S-3211—Hagedorn—Licensing of Midwives—Terminates the licensing of any midwife in the future except for renewals of existing licenses. All new applicants must comply with the requirements of S-3210. **APPROVED**

Note: S-3211 will be reconsidered by the Council on Legislation.

S-3215—Scardino—Emergency Medical Services (M.I.C.U.)—Makes the M.I.C.U. program one of indefinite duration. Provides for Annual Reports to the Legislature on all authorized projects. **ACTION DEFERRED**, pending further information from the Committee on Emergency Medical Services re pilot project results, cost effectiveness, and possibility of broadening the scope of the use of the program.

S-3216—Scardino—Testing of Newborns for Hypothyroidism and Other Diseases—Adds the following mandatory tests to those currently being conducted on newborns—a galactosemia, maple sugar urine disease, and homocystinuria. **ACTION DEFERRED**,

pending further information from the N.J. Chapter of the American Academy of Pediatrics and further research of existing statutes.

S-3249—Russo—Learning Disabilities—Deletes from existing law the term "perceptually impaired" and would substitute therefor "specific learning disability." Specific learning disability is defined as a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. **NO ACTION**

S-3282—Bedell—Auto Insurance (No Fault)—Would allow tort claims only when there is "death, serious impairment of body function, or permanent serious disfigurement." Provides for an Advisory Board which shall develop schedules of "reasonable fees for medical services" and also adjudicate disputed fees or questionable treatment. **CONDITIONAL APPROVAL**, pending deletion of Advisory Board established by the Commissioner which will deal with quality assurance measures and which has only two physicians out of five members. Plus the deletion with reference to medical care and medical fees.

SJR-3003—Gagliano—Emergency Medical Services Regulations—Directs the Health Care Administration Board to disapprove the proposed plan for emergency medical services regionalization and designation. **NO ACTION**

SR-3003—Gagliano—Emergency Medical Services Regulations—Calls upon the Health Care Administration Board to defer implementation of the Emergency Medical Services regulations until the first aid and rescue squads have had opportunity to review and comment and the Attorney General rule on the question of whether the Health Care Administration Board has jurisdiction. **NO ACTION**

A-3125—Muhler—Nuisance Suits—Allows reasonable attorneys' fees to successful defendants in the case of any frivolous claims. (Note—this also includes cross claims, third party complaints, and counter claims.) **ACTIVE SUPPORT**

A-3127—Doyle—Medical and Psychiatric Care in Correctional Institutions—Mandates medical and psychiatric care for inmates in correctional institutions provided it does not necessitate capital construction. **ACTIVE SUPPORT**

A-3128—Doyle—Voluntary Psychiatric Admissions—Requires patients who have voluntarily admitted themselves to the psychiatric units of general hospitals to submit to treatment (exclusive of electroshock) during the 72-hr. stay. (Creates implied consent) **ACTION DEFERRED**, pending further information from the NJ Psychiatric Association and the NJ Hospital Association concerning the language of this legislation.

A-3137—VanWagner—Amends the Practicing Psychology Licensing Act—Permits school psychologists to engage in private practice. **ACTION DEFERRED**, pending clarification of the language of the bill. The type of testing should indicate whether it would be psychological or psychotherapy.

A-3166—Deverin—Emergency Medical Services—Provides that the Department of Health may not adopt EMS regulations until 120 days after they have been submitted to

both legislative committees on Institutions, Health and Welfare. **ACTIVE SUPPORT**

A-3204—Herman—Mobile Intensive Care Units—Makes permanent the mobile intensive care unit program which currently is functioning under temporary status. The State Board of Medical Examiners and the State Department of Health will continue to exercise training and regulatory functions. **ACTION DEFERRED**, pending further information from the Committee on Emergency Medical Services re pilot project results, cost effectiveness and the possibility of broadening the scope of the use of the program.

A-3231—Gewertz—Mobile Intensive Care Units—Would convert the current M.I.C.U. project from a pilot program into one of ongoing and indefinite duration. **Law c.116 ('79)**

A-3245—Kern—Licensing of Nurse-Midwives—This proposal would restrict the future licensing of midwives to only those applicants who would qualify as "nurse-midwives." Licensing would be through the State Board of Medical Examiners. Permitted acts would be: To prescribe the standards of practice of nurse-midwives under the supervision of a licensed physician.

(1) Such standards shall provide, but not be limited to, that nurse-midwives shall be permitted to:

(a) Assess the woman's social, medical and obstetrical history;

(b) Perform the initial physical assessment and obstetrical evaluation;

(c) Order and evaluate standard laboratory diagnostic studies or tests including, but not limited to, CBC, urinalysis, serologic test for syphilis, blood type and Rh factor, sicklelex, rubella screening, papanicolaou smear, G.C. culture, T.B. screening, pregnancy test, PPD, anemia work-up, glucose tolerance test, thyroid profile, fetal status, chest x-ray, EKG, Rh antibody, cervical culture, throat culture, placental culture, nitrazine paper test for diagnosis of rupture of membranes, and such other laboratory diagnostic studies or tests as determined by the committee;

(d) Order nonprescription medication;

(e) Order prescription medication in accordance with approved orders of a licensed physician or upon the consultation and written prescription of a licensed physician;

(f) Provide counseling and teaching appropriate to the needs of the woman, newborn and family;

(g) Refer the woman to appropriate health and social agencies as indicated;

(h) Perform episiotomies and repair a perineal, vaginal or cervical laceration;

(i) Administer local or pudendal anesthesia during the performance of episiotomies and repairing lacerations;

(j) Provide family planning modalities including insertion and removal of IUDs;

(k) Practice nurse-midwifery in hospitals, medical clinics and other related health care facilities, including birthing centers; and

(l) Decide when and if a licensed physician should examine a woman who is under the nurse-midwife's management and care.

(2) Such standards shall provide, but not be limited to, that nurse-midwives shall:

(a) Practice nurse-midwifery under the supervision of and in consultation with a licensed physician who has current practice or training in obstetrics; and

(b) Immediately report or refer to a

licensed physician any woman with any medical or obstetrical problem or any woman with complications or deviations from normal in childbirth. **DISAPPROVED**, because the proposed legislation advocates a double standard of medical care and fosters the unlicensed practice of medicine. The recommendation of the council had been for conditional approval.

A-3246—Kern—Licensing of Midwives—Terminates the licensing of any midwife in the future except for renewals of existing licenses. All new applicants must comply with the requirements of **A-3245**. **APPROVED**

Note: A-3246 will be reconsidered by the Council on Legislation.

A-3268—Garvin—Community Mental Health Services—Changes the Community Mental Health Board function to one of advisory or advocacy as opposed to managerial or regulatory. The Department of Human Services would be granted more effective control. Civilian non-medical personnel would constitute the majority of the Board. **ACTIVE OPPOSITION**, because this is unnecessary legislation and of no benefit to the public. Existing boards already grant fair and effective control.

A-3317—Totaro—Medicaid—Creates a hearing aid for the elderly concept. Medicaid would pay 50% of the reasonable cost of a hearing aid for those over age 65 with an annual income of less than \$9,000. **CONDITIONAL APPROVAL**, pending deletion of "licensed hearing aid dispenser" and the insertion of "licensed physician."

A-3323—Schwartz—Disclosure of Laboratory Tests—Requires clinical laboratories—upon the written request of the patient—to supply the patient with a copy of the report that the laboratory sent to the physician. **ACTIVE SUPPORT**

S-3343—VanWagner—Cardio Pulmonary Resuscitation—Requires every employer of 10 or more persons to have at least one in every 50 of his employees trained in CPR. **ACTIVE OPPOSITION**, because there is no practical basis for this legislation unless there is an ongoing training program to maintain the skills of CPR.

A-3350—VanWagner—Laetrile Therapy—Amends the insurance code to provide individual and group health insurance coverage to laetrile therapy when prescribed by a "doctor of medicine." **ACTIVE OPPOSITION**, because the drug has not been proved therapeutically valid. There has been no documentation of its effectiveness in the treatment of cancer.

S-3361—VanWagner—Laetrile Therapy—Same as A-3360.

A-3383—Bornheimer—No Fault Auto Insurance—Same as S-3282.

A-3407—Visotcky—Statute of Limitations—Creates a positive Statute of Limitations in NJ which would be two years from the date of the act or two years from the date the act should have been discovered, but in no event greater than ten years. **ACTIVE SUPPORT**
AJR-3013—Schwartz—House Calls—Directs the Department of Health to conduct studies and prepare plans whereby house calls by the health professionals may be facilitated. **NO ACTION**

Fee Negotiations with Third Party Payers (Anesthesiologists) . . . Approved the fol-

lowing recommendations from the Council on Medical Services (as amended by the Board) concerning the New Jersey State Society of Anesthesiologists' negotiations with third-party payers for more equitable reimbursement for the services of their members:

1. That the Medical Society of New Jersey support the right of physicians, individually or as a group, to negotiate. (Definition of negotiation: To resolve a given problem between two or more groups of varying viewpoints in a mutually agreeable fashion.)

2. That the Medical Society assist these physicians with expert help and all resources available upon the approval of the Board of Trustees.

3. That the Medical Society reserve the right to agree or disagree with the results of the negotiations.

4. That, in cases of intra-Society conflict, there be a mechanism of mediation established to resolve difference. For example, where there is (a) failure of negotiations, (b) lack of implementation of negotiated agreement, and (c) cause for complaint arising from any negotiated issue by any group in the Society.

Note: It was pointed out that the Board wanted to avoid supporting one specialty alone and felt that the Society must delineate ground rules and develop a negotiating process applicable to any physician or group of physicians. It was noted also that the Fee Committee of Blue Shield is comprised for the most part of physicians active in the affairs of MSNJ and the Council questioned whether a physician influential in MSNJ should serve also on a committee of a commercial insurance company.

Blue Shield Medical Necessity Program . . . Approved a recommendation from the Council on Medical Services that the concept of deleting 26 additional laboratory procedures from the Blue Shield programs be accepted with the provision that physicians have the opportunity to justify the necessity of any one of these procedures for an individual patient and thus be reimbursed.

Severing Relations with Blue Shield—Resolution #14 . . . Adopted the following recommendation from the Council on Medical Services (as amended by the Board) concerning Resolution #14—

RESOLVED, that the Medical Society of New Jersey encourage its members to sever any former relationships with Blue Shield of New Jersey in the interest of dealing equally and fairly with each individual patient—

which had been referred by the House of Delegates without action:

That since participating in Blue Shield of New Jersey is a voluntary process, Resolution #14 not be adopted.

Note: The Board noted that the Council had discussed the conflict of interest concept dealing with physicians active in MSNJ who serve on committees or boards of third-party payers and requested a report from the Council when a position has been determined.

Ad Hoc Committee on Drug and Alcohol Abuse . . . Approved the following recommendations from the Ad Hoc Committee on Drug and Alcohol Abuse.

1. That the Board of Trustees approve a joint venture between the Medical Society and the State Department of Health in developing a program involving the prevention of drug and alcohol abuse, at no expense to the Society.

2. That the Medical Society of New Jersey support the measures of the government to raise the drinking age from 18 to 19 and to provide alcohol education, prevention and intervention programs for alcoholic youth.

Ad Hoc Committee on Membership and Dues Collection . . . Approved the following recommendations from the Committee on Membership and Dues Collection:

1. That the Board of Trustees approve sending a letter to each of the chiefs of staff of New Jersey hospitals requesting assistance in recruiting new staff physicians to join organized medicine.

2. That the Board of Trustees approve the development of a resolution that hospital bylaws include a provision that eligibility for staff membership be based on membership in a professional society which the physician is eligible to join.

3. That the Board of Trustees request the Board of Governors of the Medical Insurance Exchange to consider an underwriting policy that gives rating credits for acquisition of CME credits, willingness to participate in peer review and Supreme Court subpanels, and cooperation in risk management programs.

Note: In the event the Board of Governors of the Insurance Company does not agree to these concepts, the Committee will formulate a resolution to be presented for consideration at the next annual meeting, calling for the Exchange to effect these changes. It was suggested that rather than employ a premium reduction, an approach might be to recommend a surcharge for non-members of MSNJ who also benefit from the

activities of MSNJ peer review, professional liability subpanels, and so on.

Back Dues . . . Referred to the Committee on Finance and Budget the matter of payment of one year's back dues (in addition to current dues) by former members who may wish to rejoin the Society but are discouraged from doing so by the "back-dues" provision.

Diagnosis Related Groups Rate Setting Under S-446 . . . Received a report from Daniel J. O'Regan, M.D., on his attendance at meetings of the Health Care Administration Board which revealed that there are 383 DRGs and there will be 383 rates generated. Twenty-six hospitals will be accepted as the initial participants and it is expected that the program will be in operation by February 1980. The Health Care Financing Administration is very interested in this New Jersey program. The New Jersey State Department of Health is now in the process of implementing S-446, but the Health Care Financing Administration will consider it an experiment until all hospitals have been included. The Physicians Advisory Board will meet with the Commissioner of Health in September and there will be a public hearing also some time that month.

. . . Directed that a formal letter reiterating MSNJ's endorsement of the DRG project as a *pilot* program be sent to the State Department of Health at this time and at the time of the public hearing in September, with copies to the Health Care Administration Board and to all physicians on the Physicians Advisory Board.

Tuition Increases and Student Loans . . . Noted (1) that the tuition increases for medical and dental students at CMDNJ are within the limits of the government's anti-inflation measures; (2) that the current limitations on loans for medical students (under the Health Education Assistance Loans) is \$10,000 per year/\$50,000 per student, which, the Department of Higher Education believes, is adequate with other available aid; (3) that a review of the current State Graduate Insured Loan Program (which provides additional loan assistance to medical students) is being undertaken and Governor Byrne believes a task force for this purpose, as suggested by MSNJ, would be a duplication of effort; and (4) that A-263, the Physician-Dentist Loan Redemption Act, endorsed by MSNJ, is supported by the Byrne administration.

Multiphasic Screening Programs—Resolution #21 . . . Approved a recommendation from Legal Counsel that it is MSNJ's belief that the procedure called for in Resolution #21 may indeed be reasonably established by amendment to regulations adopted by the State Board of Medical Examiners concerning "automated health testing centers," effective March 1979. The appropriate agencies to which the Resolution should be directed are the State Department of Health and the State Board of Medical Examiners:

RESOLVED, that the Medical Society of New Jersey petition appropriate state agencies to require that health fairs and other multiphasic screening programs send test results directly to the patient, indicating any abnormal results and with instructions to contact his/her personal physician when appropriate; and that such test results in no case be conveyed directly to the physician named by the patient; and be it further

RESOLVED, that patients be notified by such test centers that it may be proper medical procedure for the attending physician to repeat abnormal tests.

Restrictions on Establishment of Satellite Clinics—Resolution #23 . . . Approved a recommendation from Legal Counsel that Resolution #23 be adopted (House of Delegates had taken no action other than to refer the resolution to the Board of Trustees). Counsel's opinion is that assuming the laws were amended via Resolution #23 the appropriate agencies would not be required to give any greater weight to the local medical society than they would to any other respondent; the net result is no effective change from the existing situation.

RESOLVED, that the Medical Society of New Jersey demand that the New Jersey Department of Health and the New Jersey Department of Human Services seek the advice and consultation of the local county medical society, which is most acutely aware of local medical needs, before granting permission for the establishment of a free-standing, hospital satellite clinic in a given area.

National Health Insurance . . . Directed that a letter from the Union County Medical Society, calling for development of a quality television program to present the Medical Society's point of view on national health insurance be referred to the Council on Public Relations with a copy of the following sentiments expressed by the Board:

- The Society has had difficulty developing a policy on national health

insurance—the House of Delegates, in May, took no position.

- Conflict of opinion on national health insurance exists among physicians and between MSNJ and the organizations with which cooperation was suggested in the communication from Union County.

- The Society's budget would prohibit the expenditure to present a quality television program.

- The public relations staff and consultants had developed a program in support of insurance—it is possible to get public support of "insurance" as opposed to federal or state-controlled services. (The public will not accept the concept that it has to pay the total cost of health care out of its own pocket.) Release of this program was cancelled when the House of Delegates did not support national health insurance.

- Information can be presented to the public by placing placards or frames in the waiting rooms of physicians' offices to display monthly messages and through public-interest talk shows where it could be arranged to have doctors appear.

Insurance Benefits for Psychiatric Care—Resolution #20 . . . Received a report from Doctors Bernstein and Morrison relative to Resolution #20 (p. 617, August 1979 JMSNJ), which indicated that with the possible exception of CHAMPUS, no insurance company was found that provides psychiatric benefits "equivalent in scope and duration to those benefits provided for other medical or physical illness" (as stipulated in Resolution #20 and in the AMA Council on Medical Services Report C). Two HMO/IPA groups feel that they cannot now offer this coverage at a rate competitive with other insurance plans. When full mental health benefits were included in a federal employee plan, claims rose from 14 to 123 million dollars and rates had to be increased by 50 percent. The issue appears to be a question of money—no one can afford to perform what the resolution requires. . . . Directed, in view of the above facts, that all pertinent material, including Report C of the AMA Council on Medical Services, in the matter of insurance benefits for psychiatric care be sent to the New Jersey Psychiatric Association for review, with a request that MSNJ be advised as to the proper course of action to pursue.

Resolutions from the Ocean County Medical Society . . . Referred resolutions from the Ocean County Medical Society on the subjects indicated to the Special Committee on House Maintenance, Staff Policies and Personnel Relations for consideration:

1. Distinguish rooms in MSNJ headquarters by county society names.

2. Dedicate, in honor of its Golden Merit recipients, an historical room in MSNJ headquarters to house medical objects and instruments of antiquity.

Kaleel G. Gareeb, M.D. vs. Newton Memorial Hospital . . . Directed that the Executive Director investigate a dispute between Kaleel G. Gareeb, M.D., and the Newton Memorial Hospital and report his recommendations to the next meeting of the Board of Trustees.

AMA Ad Hoc Committee on Women Physicians in Organized Medicine . . . Agreed to submit the name of Palma E. Formica, M.D., in nomination for appointment to the ten-member AMA Ad Hoc Committee on Women Physicians in Organized Medicine.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

The first center to provide clinical, referral and counseling service to victims of Huntington's Disease—and one of the very few of its kind in the nation—recently has been established at the CMDNJ-Rutgers Medical School in Piscataway.

Since Huntington's Disease is an hereditary brain disorder which can afflict an entire family, the unit is aptly named the Family Service Center for Huntington's Disease. The unit is being sponsored by CMDNJ, the New Jersey Chapter of the National Huntington's Disease Association, and the State Department of Health.

Designed to provide comprehensive and centralized care for Huntington's Disease families, the center features a family service team, composed of neurologists, psychiatrists, psychologists, geneticists, counselors, and internists who work with these families to help

them to cope with the problems associated with the disease.

This fall, the Family Service Center will begin providing clinical services at Middlesex General Hospital, New Brunswick, which is developing as the core teaching hospital for the CMDNJ-Rutgers Medical School. Other components of the center will be a 24-hour hotline, (201) 463-4372, and a referral service, both of which will be free.

A research program and a brain tissue collection program are being developed as a further addition to the center. Clinical services will be provided on a sliding scale basis, and no one will be turned away.

Unique as it is in the state of New Jersey, the center represents but one of the several specialized centers and clinics established by CMDNJ in recent months to which physicians throughout the state can refer their patients for diagnosis or treatment.

Also scheduled to open this fall at the CMDNJ College Hospital in Newark is a new Multiple Sclerosis Diagnostic and Treatment Center, which will serve the Greater Newark area and will be a referral base for the entire state. Multiple sclerosis affects 50 to 70 persons per 100,000 population, and it is estimated that as many as 5,000 New Jerseyans suffer from the disease.

The sophisticated new unit will boast the most modern equipment available and a team of specialists that includes physicians, nurses, social workers, psychologists, and physical therapists.

As with any of CMDNJ's health care services, the Multiple Sclerosis Center will be available to all requiring its services, regardless of ability to pay. However, indigent patients will get additional assistance through a memorial gift from the National Multiple Sclerosis' Upper New Jersey Chapter, located in Montclair. The donation was made in memory of the late Mrs. Mitzi Wane, who was a multiple sclerosis volunteer worker.

The transition of services to Middlesex General Hospital by the CMDNJ-Rutgers Medical School is resulting in the establishment of another comprehensive program of health care services, this one for children. The largest of its kind in Central Jersey, the general and specialized childhood health services program is being started, or expanded, at both Middlesex General and St. Peter's Hospital, also in New Brunswick. Until now, the medical school's pediatric services have been based at Raritan Valley Hospital, Green

Brook, which has served as the school's teaching hospital since 1970.

Most of the school's pediatric facilities, including pediatric intensive care, inpatient and ambulatory units, and a Child Development Program and Child Evaluation Center, are being moved into Middlesex General. A neonatal intensive care unit, for newborns and infants with special problems, will be based at St. Peter's, a short distance away.

The move to Middlesex General, which will take about three years to complete, was highlighted last September with the transfer of three specialty services in the CMDNJ-Rutgers Medical School's department of obstetrics and gynecology. Now being offered at Middlesex General for the first time, the three services are gynecologic oncology, reproductive endocrinology, and family planning.

The oncology and infertility services generally are provided through the referral of a private physician, although inquiries can be made directly to the hospital. Appointments for family planning, a counseling service, are available directly through the hospital.

Prior to the move of the obstetrics-gynecology department to the hospital, one other unit—the division of liver diseases—was established there by the medical school. When the transition is complete, the hospital will have added 11 tertiary or specialty units, making it a major referral center. Other services will include open heart surgery, pulmonary medicine, kidney dialysis and transplantation, vascular and neurosurgery, and pediatric intensive care.

Meanwhile, New Jersey's first comprehensive hemophilia care center soon will complete its third year of operation at the Raritan Valley Hospital. The facility provides ambulatory care services for all patients referred to it and, when necessary, in-hospital care, too.

Offering a wide range of outpatient and counseling services to hemophiliacs and their families, the center serves as a central reference point for professional consultation and support. It also provides counseling for schools and for potential employers of hemophiliacs, to eliminate misconceptions about the disease.

The care center was developed by the division of hematology of CMDNJ-Rutgers Medical School with the support of the State Department of Health and the Hemophilia Association of Northern New Jersey.

At both CMDNJ-Rutgers Medical School and the CMDNJ-New Jersey

Medical School comprehensive counseling services are being operated to seek prevention of such genetic diseases as Down Syndrome (mongolism), sickle cell anemia, and Tay-Sachs. Taking family history, physical examinations and laboratory tests into account, the services attempt to predict the risk of often incurable genetic ailments occurring in yet-to-be-born children.

Each service is operated by the school's department of pediatrics' division of medical genetics, which is funded, in part, by a grant from the National Foundation-March of Dimes. Each counseling service is conducted by a staff of physicians and geneticists, professional counselors and other medical school physician-specialists serving as consultants. Thus, if a heart ailment is suspected, a cardiologist is called in. Although each is mainly a referral service for physicians, it can be contacted directly by individuals who suspect a need for its services.

Just last May, an eye research center for the diagnosis and treatment of eye diseases and the rehabilitation of the visually handicapped was dedicated by the Lions Sight Foundation of New Jersey at the CMDNJ-New Jersey Medical School.

The foundation is a non-profit organization made up of representatives from 320 Lions Clubs throughout the state. Its aim is to provide equipment and instruments to be used in eye care, financial assistance for research and care, and to encourage preventive eye health care.

Release of Patient Records Re Contact Lens

Board of Medical Examiners' Interpretation of N.J.A.C. 13:35-6.12

The Board of Medical Examiners' interpretation of the Release of Patient Records as it relates to contact lens specifications is in keeping with the spirit of a recent court decision concerning Release of Contact Lens Specifications by Optometrists. The Board's formal policy ruling is as follows:

The Board, upon motion made and duly seconded, ruled that "k" readings on contact lenses are not required to be released directly to the patient in ac-

cordance with the Release of Patient Records Rule N.J.A.C. 13:36-6.12, which provides for a physician to withhold such records when in his professional opinion, it would be deleterious to the patient's best interests. The licensed physician must release contact lens specifications to any other licensed physician, optometrist, or ophthalmic dispenser at the patient's request.

Report from the Foundation

**Daniel J. O'Regan, M.D.
Medical Director**

The officers of the New Jersey Foundation for Health Care Evaluation for the coming year are:

President
Jack E. Shangold, M.D.
President-Elect
Howard Zeidman, M.D.
First Vice President
George L. Benz, M.D.
Second Vice President
Edward Josell, D.O.
Secretary-Treasurer
John R. O'Brien, M.D.

A vote of special thanks to our immediate past president, James A. Rogers, M.D.—Dr. Rogers is recuperating from surgery, and we look forward to his return to action.

We wish our new officers the best. They represent collective experience with peer review, quality assurance, PSRO, and the IPA concept, plus the other issues which concern the New Jersey Foundation for Health Care Evaluation and our colleagues. Our board members and officers remain faithful and devoted to the Foundation's activities. They are busy practitioners and receive no compensation at all for the time they devote to the New Jersey Foundation for Health Care Evaluation duties.

One of the members of our original Board has been honored by his colleagues. Floyd Kregel, D.O., of Asbury Park, is President-Elect of the American Osteopathic Association. All New Jersey physicians can appreciate Dr. Kregel's recognition by his national society.

By the time this is published, New Jersey Foundation for Health Care Evaluation's offices will have been moved to our own quarters in the Medical Society building. We continue to enjoy close relationships with the Medical Society, and the rent that we pay helps with some of the bills.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Hector R. Felbarg, M.D., 12 Kingsley Road, Huntington, New York 11743. Cordoba (Argentina) 1957. Board certified. Fee-for service. Available.

CARDIOLOGY—Lee M. Krause, D.O., 239 Brydon Road, Philadelphia, PA 19151. Phila. College of Osteopathy 1975. Also general internal medicine. Board eligible. Solo, group, partnership. Available July 1980.

Thomas J. Maley, M.D., 2525 South Boulevard, Idaho Falls, ID 83401. CMDNJ 1970. Also general internal medicine. Board certified (both). Group or partnership, prefer hospital-based. Available. Joseph Chathampadathil, M.D., 3910 Powelton Avenue, Apt. 505, Philadelphia, PA 19104. Trivandrum (India) 1968. Also general internal medicine. Board certified (IM). Institutional, solo, or group. Available July 1980.

George Demidowich, M.D., 501 Stuyvesant Avenue, Irvington 07111. New York Medical College 1975. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1980.

CARDIOVASCULAR DISEASES—Lee Merrill Krause, D.O., 239 Brydon Road, Philadelphia, PA 19151. Phila. College of Osteopathic Medicine 1975. Also general internal medicine. Board eligible (IM). Solo, single or multi-specialty group, partnership. Available July 1980.

DERMATOLOGY—David Herschthal, M.D., 6924 SW 114th Place, Miami, FL 33173. New York Medical 1976. Solo, multi-specialty group, partnership. Available June 1980.

FAMILY PRACTICE—Frazil Kideys, M.D., 17 Agate Street, East Brunswick 08816. Istanbul 1953. Board eligible. Partnership or solo. Available.

GASTROENTEROLOGY—Robert D. Lafsky, M.D., 3605 Weightman Street, Philadelphia, PA 19129. University of Pennsylvania 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

GENERAL PRACTICE—Bruce M. W. Burns, M.D., 930 Steib Terrace, Union 07083. Michoacan (Mexico) 1977. Sub-specialty, psychiatry. Any type practice. Available.

Thomas W. Lister, M.D., Route 3, Box 417 CD, Cameron, TX 76520. University of Texas 1968. Group, partnership, industrial, student health. Available.

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GYNECOLOGY—Arthur G. Murphy, M.D., 1491 Janet Place, Englewood, FL 33533. Cornell 1940. School health, institutional, administrative. Available.

INTERNAL MEDICINE—Kamran Hassidim, M.D., 4303 Caminito Del Zafiro, San Diego, CA 92121. Tehran (Iran) 1971. Subspecialties, hematology, oncology. Board eligible. Any type practice. Available.

Martin S. Lerman, M.D., 3307 Canongate Road, Apt. 10, Fairfax, VA 22031. Georgetown 1973. Board certified. Any type practice. Available.

Stuart H. Packer, M.D., 3406 Denise Street, Durham, DC 22704. SUNY-Downstate 1974. Special interest, hematology/oncology. Board certified. Group or partnership. Available July 1980.

Nanda K.S. Iyengar, M.D., 185 Ardsley Loop, Apt. 17-D, Brooklyn, New York 11239. Mysore (India) 1971. Special interest, cardiology. Any type practice. Available.

Abdul Majeed, M.D., 11-01 Kennedy Boulevard, North Bergen 07047. Dow (Pakistan) 1975. Board eligible. Institutional, solo, partnership. Available.

Miguel A. Maseda, M.D., 105 Fifth Avenue, Bradley Beach 07720. Madrid 1977. Single-specialty group, partnership, solo. Available July 1980.

Robert B. Liberman, M.D., 51 Harnden Avenue, Watertown, MA 02172. CMDNJ 1977. Single or multi-specialty group, partnership, research, institutional, solo. Available July 1980.

Sriram Sudarshan, M.D., 1100 Parsippany Boulevard, Apt. 263, Parsippany 07054. Gandhi Medical College (India) 1968. Subspecialty, cardiology. Board certified. Solo or partnership. Available.

James W. Baird, M.D., 1500 Locust Street, Apt. 3312. Philadelphia, PA 19102. Johns Hopkins 1968. Subspecialty, physical medicine and rehabilitation. Board certified. Multi-specialty group, partnership, solo. Available August 1980.

David A. Stein, M.D., 3811 Bluebonnet Boulevard, Houston, TX 77025. New York Medical 1975. Subspecialty, pulmonary diseases. Board certified. Partnership, institutional, multi-specialty group. Available October 1980.

Bennett H. Bruckner, M.D., 192 Garth Road, Apt. 6-M, Scarsdale, New York 10583. Emory 1973. Board eligible. Group, partnership, solo. Available.

Barton E. Cohen, M.D., 166 East 34th Street, Apt. 10-G, New York, NY 10016. NYU 1975. Subspecialty, cardiology. Board certified. Group, partnership. Available July 1980.

Jam Stanley Glowacki, M.D., 29 Maple Avenue, Fair Haven 07701. Jefferson 1977. Board eligible. Solo, partnership, group. Available July 1980.

Miguel A. Maseda, M.D., 106 Fifth Avenue, Bradley Beach 07720. Madrid 1977. Board eligible. Solo, group, partnership. Available July 1980.

Iradj Shairm, M.D., 89 Central Avenue, Morrisville, PA 19067. Iran 1970. Board certified. Partnership, group. Available.

Richard J. Fastiggi, M.D., 14 W. Cold Spring Lane, Apt. 302, Baltimore, MD 21210. CMDNJ 1977. Board eligible. Emergency room. Available July 1980.

NEPHROLOGY—Dariush Arfaania, M.D., 1718 E. Broadway, Apt. D, Columbia, MO 65201. Pahlavi (Iran) 1973. Also general internal medicine. Board eligible (IM). Institutional, single or multi-specialty group. Available January 1980.

NEUROLOGY—Ahmad Y. Haffar, M.D., 1905 Faith Place, Gretna, LA 70053. Damascus (Syria). Solo, group, or partnership. Available.

OBSTETRICS/GYNECOLOGY—Richard J. Malafy, M.D., Box 31, Frankstown Road, Hollidaysburg, PA 16648. CMDNJ 1971. Board eligible. Group or partnership. Available.

Jose S. Kua, M.D., 9503 Peartree Lane, Cypress, CA 90630. Santo Tomas (Philippine) 1971. Subspecialty, general practice. Board certified. Solo, partnership, single-specialty group. Available January 1980.

Yacov Tal, M.D., 2356 Mickle Avenue, Bronx, NY 10469. Tel Aviv (Israel) 1976. Partnership, single or multi-specialty group. Available July 1980.

Alejandro F. Aguilar, M.D., 602 Patterson Road, Bethel Park, PA 15102. San Agustin (Peru) 1969. Board eligible. Multi-specialty group, partnership, solo. Available January 1980.

Zuhair M. El Kalaadui, M.D., 100 Boteler St., Apt. 1106, Ottawa, Canada K1N 8Y1. Ain Shams (Egypt) 1972. Board eligible. Single or multi-specialty group, partnership. Available January 1980.

Michael T. Kicenuik, M.D., 49 Crescent Road, Livingston 07039. CMDNJ 1976. Group, partnership, solo, or industrial. Available July 1980.

Pabilto S. Luz, M.D., 3506 Camellia Circle, Columbus, OH 39701. Far Eastern (Philippines) 1962. Board eligible. Partnership, single-specialty group, solo. Available March 1980.

Theodore Kohn, M.D., 6441 N. Francisco Avenue, Chicago, IL 60645. Mexico 1962. Board eligible. Solo, partnership, group. Available.

Khalid Parwez, M.D., 420 Stockholm Street, Apt. C-9, Brooklyn, New York 11237. Nishtar (Pakistan) 1971. Board eligible. Group, partnership, association. Available July 1980.

Robert A. Stern, M.D., 7 Balint Drive, Apt. 128, Yonkers, NY 10710. New York Medical College 1976. Board eligible. Group. Available July 1980.

ONCOLOGY—Stanley Ostrow, M.D., 9 Wychwood Court, Baltimore, MD 21209. SUNY-Downstate 1974. Also general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available June 1980.

OPHTHALMOLOGY—Wilma K. Brucker, M.D., 669-7 Willow Bend Drive, Clarkson, GA 30021. Med. College of PA 1972. Board certified. Solo, multi-specialty group, ophthalmology group, or academic (not in large urban area). Available December 1979.

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Ira Goodman, M.D., 643 West Barry, Chicago, IL 60657. Loyola 1974. Board certified. All types practice. Available November 1979.

Steven N. Cohen, M.D., 1355 Palos Verdes Drive, San Matco, CA 94403. Cornell 1974. Board eligible. Solo, partnership, single-specialty group. Available.

Jerrold E. Ziperstein, M.D., 1900 Lyttonville Road, Apt. 1314, Silver Spring, MD 20910. Montpellier (France) 1973. Board eligible. Partnership, single-specialty group, solo. Available.

Gregory I. Goldman, M.D., Texas Tech. University School of Medicine, Dept. of Ophthalmology, Lubbock, TX 79409. Far Eastern (Philippines) 1976. Solo, partnership, single or multi-specialty group. Available July 1980.

OTOLARYNGOLOGY—Howard Taylor, M.D., 1560 North Sandburg Terrace, Apt. 3408, Chicago, IL 60610. Columbia 1976. Board eligible. Partnership, solo, group, or academic affiliation. Available July 1980.

OTORHINOLARYNGOLOGY—Jeffrey Adelgass, M.D., 12 East 86th Street, New York, NY 10028. Board eligible. Group, partnership, solo. Available July 1980.

PATHOLOGY—N. Mirzabeigi, M.D., 603-B South Trenton Avenue, Pittsburgh, PA 15221. Teheran (Iran) 1967. Board certified (anatomical and clinical pathology). Associate or assistant. Available.

Singh C. Mohinder, M.D., 470 Gale Boulevard, Melvindale, MI 48122. Maulana (India) 1970. Partnership, multi-specialty group, research. Available January 1980.

PEDIATRICS—Martin M. Fisher, M.D., Division of Adolescent Medicine, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042. Einstein 1975. Subspecialty, adolescent medicine. Board eligible. Group, partnership, institutional. Available July 1980.

Nelly A. Marklein, M.D., 88-34 Rutledge Avenue, Glendale, NY 11227. Santo Tomas (Philippines) 1963. Board certified. Multi-specialty group, solo, public health. Available January 1980.

Anju K. Khanijou, M.D., 260-14 74th Avenue, Glen Oaks, Queens, NY 11004. All-India 1973. Board eligible. Single or multi-specialty group, institutional. Available January 1980.

Bernardita T. Gabriel, M.D., 52-15 Seabury Street, Elmhurst, NY 11373. Santo Tomas (Philippines) 1972. Board eligible. Partnership, single or multi-specialty group. Available.

PEDIATRIC HEMATOLOGY/ONCOLOGY—Sudhakar S. Chagavath, M.D., 110-52 63rd Drive, Forest Hills, NY 11375. G.S. Medical College (India) 1971. Board certified (Pediatrics). Any type practice. Available July 1980.

PHYSICAL MEDICINE/REHABILITATION—Jeffrey A. Brustein, M.D., 777

Pelham Road, Apt. 2-B, New Rochelle, NY 10805. Creighton 1976. Partnership, group, solo. Available July 1980.

PSYCHIATRY—Marc Rothman, M.D., Presidential Apts., Apt. C-822, City Line and Presidential Blvd., Philadelphia, PA 19131. SUNY-Upstate. Board eligible. Group, partnership, hospital. Available July 1980.

Pradeep Rattan, M.D., 1926 West Harrison, Apt. 1214, Chicago, IL 60612. Calcutta (India) 1972. Board eligible. Institutional single-specialty group, partnership. Available.

RADIOLOGY—Robert Baran, M.D., 31 Crest Lake Drive, Oak Ridge 07438. SUNY 1972. Board certified. Hospital or office-based group in northern New Jersey. Available.

RHEUMATOLOGY—Zahid Husain, M.D., 60 Presidential Plaza, Apt. 1208, Syracuse, NY 13202. Dacca (Pakistan) 1972. Also general internal medicine. Board certified (IM). Partnership, solo, multi-specialty group. Available October 1980.

Christopher J. Lynch, M.D., 130 Stanton Court West, Pittsburgh, PA 15201. Cornell 1975. Also general internal medicine. Board certified (IM). Solo, group, partnership. Available July 1980.

SURGERY, CARDIOVASCULAR—Cesar P. Veluz, M.D., 1200 North State Street, Box 1930, L.A. County USC Medical Center, Los Angeles, CA 90033. University of the Philippines 1971. Special interest, thoracic surgery. Board eligible (general surgery). Single or multi-specialty group, partnership. Available.

Naweed K. Majid, M.D., Box 85, USAF Hospital, USAF, APO NY 09220. King Edward (Pakistan) 1967. Special interest thoracic surgery. Board certified (general surgery). Single or multi-specialty group, institutional. Available July 1980.

Peter Y. Chang, M.D., 3450 Wayne Avenue, Apt. 26-J, Bronx, NY 10467. Taipei (Taiwan) 1970. Special interest, general surgery. Board certified (general surgery). Any type practice. Available.

S.A. Paruk, M.D., 3131 Whitehorn Road, Cleveland Heights, OH 44118. Natal (South Africa) 1970. Special interest in thoracic and general surgery, transplantation. Board certified (general surg.) Group, academic, solo. Available July 1980.

Charles H. Antinori, M.D., 4400 Memorial Drive, Apt. 1019, Houston, TX 77007. Harvard 1973. Special interest, thoracic surgery. Board eligible (general surgery). Single-specialty group, solo, research. Available July 1980.

SURGERY, GENERAL—Rajesh Khanijou, M.D., 260-14 74th Avenue, Glen Oaks, Queens, NY 11004. All India 1973. Board eligible. Single or multi-specialty group, partnership, institutional. Available January 1980.

Raduf B. Korkor, M.D., 7600 Kirby Drive,

Apt. 1313, Houston, TX 77030. Damascus (Syria) 1973. Special interest, colon and rectal surgery. Board eligible (general surgery). Single or multi-specialty group, partnership, solo. Available.

Sahibzada A. Ahmed, M.D., 501 Sixth Street, Apt. 3-J, Brooklyn, NY 11215. Dacca (Bangladesh) 1970. Board eligible. Solo, group, hospital-based. Available July 1980.

F. Wesner Fleurant, M.D., 103 Gail Drive, New Rochelle, NY 10805. Haiti 1959. Special interest, vascular surgery. Board certified. Group, association, partnership, institutional, industrial, solo. Available.

SURGERY, ORTHOPEDIC—Victor Tseng, M.D., 1019 Everett Avenue, Apt. 3, Louisville, KY 40204. SUNY-Downstate 1970. Special interest, hand surgery. Board eligible. Single-specialty group, partnership, solo. Available November 1979.

Kaushal K. P. Sinha, M.D., 3513 Cairnbrook Drive, Columbia, SC 29210. Prince of Wales (India) 1966. Board eligible. Solo, partnership, single-specialty group. Available.

Stephen L. Brenner, M.D., 350 East 17th Street, Apt. 17-A, New York, NY 10003. Guadalajara 1974. Single or multi-specialty group, partnership. Available July 1980.

Elliot N. Lang, M.D., 356 Central Avenue, Scarsdale, NY 10583. Temple 1975. Board eligible. Solo, group, partnership. Available July 1980.

SURGERY, UROLOGICAL—Fredy E. Delacruz, M.D., Box O, Balboa Heights, Balboa, Canal Zone. Guadalajara 1972. Board eligible. Partnership, solo, institutional, multi- or single-specialty group. Available November 1979.

Philip L. Miller, M.D., 333 East 30th Street, Apt. 18-B, New York, NY 10016. Chicago 1973. Partnership, single or multi-specialty group. Available July 1980.

Vodur C. Reddy, M.D., 1571 Main Street, Apt. 26, West Warwick, RI 02893. Guntur (India) 1961. Partnership, single or multi-specialty group. Available July 1980.

Richard Kroll, M.D., 16 Pick Avenue, Fort Leavenworth, KS 66027. Albany, New York 1972. Board eligible. Partnership or single-specialty group. Available July 1980.

UROLOGY—Stuart Bergman, M.D., 306 Eastbrook Drive, Charlottesville, VA 22901. Cornell 1973. Board eligible. Group or partnership. Available July 1980.

Yih-Wen Lai, M.D., 4219 Oakcrest Drive, Lorain, OH 44053. Taipei (Taiwan) 1964. Board eligible. Solo, group, partnership. Available.

Talal Samhan, M.D., Good Samaritan Hospital, Cincinnati, OH 45220. Mosul (Iraq) 1972. Partnership, institutional, group, solo. Available July 1980.

Eugene De Salvo, M.D., 400 Rutherford Boulevard, Clifton 07014. CMDNJ 1975. Solo, partnership, group. Available July 1980.

Maimonides

August 14, 1979

Dear Dr. Krosnick:

Your editorial on Maimonides in the August issue of *The Journal* (76:569, 1979) was a gem. It brought back to both my wife and myself our wonderful visit to Cordova, Spain some years ago. I also appreciated being introduced to Ben Shahn's calligraphic tribute to Maimonides.

(signed) Harry A. Pinsky, M.D.

Blue Shield Utilization Review

August 23, 1979

Dear Dr. Krosnick:

Thank you for your letter with the attached inquiry from Dr. Hudacek (see *J Med Soc NJ* 76:705 (Sept) 1979). Actually, in your letter you've touched on the answer, which basically is that we're talking about two things. The advertisement in *The Journal* refers to Blue Shield Utilization Review, while Dr. Hudacek's letter refers to hospital Utilization Review Committee activities; the two are unrelated.

I do not speak for Blue Cross which is, as you know, a separate organization; but I have obtained certain information from them, which is related below.

Hospital Utilization Review Committees are involved basically in cost containment activities related to hospital admissions (medical necessity and length of stay), primarily by means of concurrent review. Such activities are obviously of interest primarily to Blue Cross, which pays hospitals. As you know, PSRO's now are involved actively in such review with respect to Medicare and Medicaid patients; and there are certain arrangements for reimbursement

of physicians for review activities. I am told that Blue Cross has explored ways of similarly reimbursing physicians for review specifically involving Blue Cross patients. However, several years ago, the commissioners of both the Department of Health and the Department of Insurance have said that they wouldn't allow cost of physician reimbursement for utilization review to be included in calculation of hospital per diem rates, or in Blue Cross premium rates. And that is the reason why Blue Cross can't pay for hospital Utilization Review.

On the subject of *The Journal* ad, "Blue Shield Utilization Review," this has to do with services rendered by physicians (and other Blue Shield providers), and is directed toward assurance of proper utilization of Blue Shield benefits. This is accomplished primarily by retrospective review, and is performed by Blue Shield personnel—utilization analysts, with assistance and advice from Plan medical staff, and from outside medical consultants when needed. Hospital Utilization Review Committees ordinarily are not involved.

I trust this satisfactorily answers the questions. I'd be glad to discuss any of this further with you if needed.

(signed) Charles L. Cuniff, M.D.
Vice-President, MSP

Medicare Payment in Estate Cases

August 24, 1979

Dear Doctor Krosnick:

The response to your editorial, "Are No Ethics Sacred," by Doctor Christopher T. Reilly in the August issue of *The Journal* (76:628) may mislead physicians and prevent them from receiving the maximum allowable reimbursement for their services.

Doctor Reilly addressed the problem of the Medicare settlement of unpaid bills in estate cases. A physician may accept assignment when submitting a claim for the care of a patient who has expired. He will receive direct payment of the maximum allowable amount and he always has the right to request reconsideration of any disallowances. If a physician elects not to accept assignment, he may bill the estate; the estate can pay the bill in full and in turn submit the claim to Medicare; Medicare *will* reimburse the estate the maximum allowable amount.

Contrary to Doctor Reilly's statement in the third paragraph of his letter, the physician *can insist* "on a direct payment from the estate" for whatever he considers to be his regular and customary fee for his services and Medicare *will* reimburse the estate to the limit of its liability. Doctor Reilly's statement that "Medicare allows nothing once the patient has died" is not accurate.

Contrary to the statements in the letter, it is advised that regardless of either the source or the amount of reimbursement, regardless of acceptance or nonacceptance of assignment, and regardless of billing either the patient or his estate, physicians are advised always to submit their current regular and customary fee for their services and *not* discount, forgive the co-insurance, or otherwise reduce their regular fee.

Many thousands of estate cases involving Medicare cases are resolved each year through acceptance of assignment by physicians and payments to the executors of estates for the Medicare expenses of the deceased. These comments are made to offer a more complete picture of what has been made to appear to be an ethical issue and one which is actually a legal issue.

I trust this information will be of assistance to New Jersey physicians.

(signed) James E.D. Gardam, M.D.
Vice-President, Medical Services
Government Health Programs Office
Prudential Insurance Company

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CME CALENDAR

ANESTHESIOLOGY

Nov.

- 20 Annual Meeting**
Ramada Inn, Clark
(*NJ State Society of Anesthesiologists and AMNJ*)

MEDICINE (includes Family, Internal, and General Medicine and Dermatology)

Nov.

- 1 The Environment and Cancer**
9:30 a.m.-12:30 p.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)
- 2 Preservation of the Ischemic Myocardium**
8 a.m.-4:30 p.m.
- 3 9 a.m.-4:30 p.m.**—Fairmont Hotel Phila., Pa.
(*Deborah Heart and Lung Center*)
- 6 Pediatric Blood Disorders**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 6 Acute Myelogenous Leukemia and Thorotrast**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 6 Dermatology**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 6 Estrogen Replacement Therapy**
- 13 Hypertension in Cardiovascular Renal Disease**
- 27 C.O.P.D.**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 7 The Difficult Patient with Diabetes**
8:30 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(*American Diabetes Association, NJ Affiliate, and AMNJ*)
- 7 Urinary Tract Infection**
- 14 To be announced**
- 21 Limiting Myocardial Infarct Size**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 7 Medical Lecture Series**
- 14 1-3 p.m.**—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 28 Malignant Hypertension**
8:30-9:30 p.m.—Riverside General Hospital, Boonton
(*Riverside General Hospital and AMNJ*)
- 7 The Difficult Patient with Diabetes**
8:30 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(*American Diabetes Association, NJ Affiliate, and AMNJ*)
- 7 Acute Respiratory and Mechanical Ventilation**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)
- 7 Hypertension**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)
- 7 Trace Elements in Nutrition**
- 14 Medical Lecture Series**
- 21 1-3 p.m.**—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 28 Urinary Tract Infection**
- 14 To be announced**
- 21 Limiting Myocardial Infarct Size**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 7 Controversies in Arrhythmology**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(*Dover General, Riverside and St. Clare's Hospitals*)
- 7 Cardiology Conferences**
- 21 4-6 p.m.**—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 8 Irritable Bowel Syndrome**
8-9 p.m.—Zurbrugg Memorial Hospital, Riverside
(*Burlington County Medical Society and AMNJ*)
- 10 Care of the Elderly**
9 a.m.-4 p.m.—Stevens Institute, Hoboken
(*Hudson County Medical Society and Hospitals in Hudson County*)
- 10 Medical and Surgical Aspects of Bleeding and Thrombosis**
8:30 a.m.-1 p.m.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)
- 13 Malignant Hypertension**
8:30-9:30 p.m.—Riverside General Hospital, Boonton
(*Riverside General Hospital and AMNJ*)
- 13 Updates on Sterilization Procedures**
- 20 Treatment of Viral Hepatitis**
- 27 Updates on New Drugs**
8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)
- 13 Problem Skin Cancers**
8-10 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 13 Rheumatology**
2 p.m.—Ancora Psychiatric Hospital
(*AMNJ*)
- 14 Hypertensive Crises**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 14 Advances in Pulmonary Diseases**
9 a.m.-5 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 14 Treatment of Chronic Bronchitis**
- 21 Neuroendocrinology in Clinical Practice**
- 28 Differential Diagnosis of Pneumonia**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AAFP, and AMNJ*)
- 15 Newer Therapeutic Regimes in Hypertension**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 20 Emergency Care**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 20 Proper Use of Endoscopy**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 21 Use of Prednisone in Pulmonary Disease**
11:30 a.m.-1 p.m.—VA Medical Center East Orange
(*VA Medical Center and AMNJ*)
- 21 Neonatal Problems**
4 p.m.—Jersey City Medical Center
(*AMNJ*)
- 21 Upper G.I. Bleeding**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 21 Cardiac Rehabilitation**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)

Dec.

- 4 Diabetes**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 4 Diabetes Mellitus—Today and Tomorrow**
8-10 p.m.—Saddle Brook General Hospital
(*Saddle Brook General Hospital and AMNJ*)
- 4 Hyperlipidemia**
- 11 Myocardium**

8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)

4 Indications for Endoscopy

11 Oral Lesions in General Practice

18 Spondyloarthritis

8-9 a.m.—Garden State Community Hospital, Marlton
(*Garden State Community Hospital and AMNJ*)

5 Laboratory Interpretations

10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)

5 Evaluating the Patient with Chest Pain

12 To be announced

9:30-11 a.m.—Bergen Pines County Hospital, Paramus
Bergen Pines County Hospital and AMNJ

5 Obesity

12 Medical Lecture Series

19 1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)

11 Gastrointestinal Bleeding

2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)

11 Hematology

8:30 p.m.—Fair Lawn Memorial Hospital
(*AMNJ*)

12 Migraine and Its Equivalents

9:30-11:30 a.m.—Riverside Hospital, Boonton
(*Dover General, Riverside, and St. Clare's Hospitals*)

12 Drug-Induced Diseases

19 Contemporary Treatment of Arthritis

9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital*)

18 Newer Drugs for Hypertension

12 noon—St. Mary's Hospital, Orange
(*AMNJ*)

18 Gastrointestinal Bleeding

11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)

19 Cor Pulmonale

11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)

21 Proper Use of Antibiotics

12 noon—Freehold Area Hospital
(*AMNJ*)

NEUROLOGY/PSYCHIATRY

Nov.

1 Prediction Methods for Doses in Clinical Psychiatry

8 Neuroleptics: When, How, Why, and Why Not?

15 Cognitive Therapy of Depression

29 Schizophrenia, Tardive Dyskinesia and Tourette Syndrome

12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

1 Case Seminars

8-10 p.m.—312 Harding Drive, So. Orange
(*Advanced Psychiatric Group and AMNJ*)

1 Psychiatric Lecture Series

8 11 a.m.-12 noon—Greystone Park

15 Psychiatric Hospital

29 (*Greystone Park Psychiatric Hospital and AMNJ*)

2 Psycho-Social Aspects of Depression

8:30 a.m.-5:30 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)

2 Psychiatric Lecture Series

9 1:30-5 p.m.—Trenton Psychiatric

16 Hospital

23 (*Trenton Psychiatric Hospital and*

30 *AMNJ*)

5 Neuroscience Conferences

12 11:30 a.m.-12:30 p.m.—Bergen Pines

19 County Hospital, Paramus

26 (*Bergen Pines County Hospital and*

AMNJ) (*Essex Psychiatric Seminar and AMNJ*)

7 Dinner Meeting

Details to be announced
(*CMDNJ-NJ Medical School, Dept. of*

7 Seminar on Loneliness

10 a.m.-3 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

7 Hyperventilation Syndrome

9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital, AAFP, and*

AMNJ)

7 Psychotherapy with the Borderline

14 Patient

8-10 p.m.—Hackensack Hospital

(*NJ Psychoanalytic Society and AMNJ*)

7 Couples Therapy

14 Evaluation of Adolescents

21 Evaluation of Adolescents-Non-Psychotic

1-3 p.m.—Ancora Psychiatric Hospital, Hammonton

(*Ancora Psychiatric Hospital and AMNJ*)

8 Sino-American Psychiatric Study of the

Republic of China

11:30 a.m.-1 p.m.—Muhlenberg Hospital, Plainfield

(*Muhlenberg Hospital*)

14 Grand Rounds in Psychiatry and Mental

28 Health Science

1:30-3 p.m.—NJ Medical School, Newark

(*CMDNJ and AMNJ*)

21 Distinguished Speakers Series

1:30-3 p.m.—NJ Medical School, Newark

(*CMDNJ and AMNJ*)

28 Cults and Totalism—A Psycho-historic

Perspective

8-10:30 p.m.—South Orange Junior

High School

(*Essex County Mental Health*

Association, NJ Psychiatric Association

and AMNJ)

28 Psychological Issues and Illness

9:30-11 a.m.—Bergen Pines County

Hospital, Paramus

(*Bergen Pines County Hospital and*

AMNJ)

Dec.

3 Psychotherapy with a Chronic

Schizophrenic

8-10 p.m.—192 Chittenden Rd., Clifton

(*Essex Psychiatric Seminar and AMNJ*)

3 Neuroscience Conferences

10 11:30 a.m.-12:30 p.m.—Bergen Pines

17 County Hospital, Paramus

(*Bergen Pines County Hospital and*

AMNJ)

5 Neurological Problems of Infancy and Childhood

9-11 a.m.—Roosevelt Hospital, Menlo Park

(*Middlesex General Hospital, AAFP and*

AMNJ)

5 Distinguished Speakers Series

19 1:30-3 p.m.—NJ Medical School, Newark

(*CMDNJ and AMNJ*)

5 Psychiatric Lecture Series

12 1-3 p.m.—Ancora Psychiatric Hospital,

19 Hammonton

(*Ancora Psychiatric Hospital and AMNJ*)

6 Psychiatric Lecture Series

13 11 a.m.-12 noon—Greystone Park

20 Psychiatric Hospital

27 (*Greystone Park Psychiatric Hospital and*

AMNJ)

6 Case Seminars

8-10 p.m.—312 Harding Drive, So. Orange

(*Advanced Psychiatric Group and AMNJ*)

6 Behavior Therapy

13 Combining ARU and Hypocrites

12 noon-1 p.m.—Carrier Foundation, Belle Mead

(*Carrier Foundation*)

12 Grand Rounds in Psychiatry and

26 Mental Health Science

1:30-3 p.m.—NJ Medical School,

Medical Science Bldg., Newark

(*CMDNJ-NJ Medical School and*

AMNJ)

13 Obesity and its Treatment

8-9 p.m.—Mount Holly Center

62 Richmond Ave., Mt. Holly
(*Burlington County Medical Society and*

AMNJ)

13 What Is Liaison Psychiatry?

11:30 a.m.-12:30 p.m.—Muhlenberg Hospital, Plainfield

(*Muhlenberg Hospital*)

19 Movement Disorders

9:30-11 a.m.—Bergen Pines County

Hospital, Paramus

(*Bergen Pines County Hospital and*

AMNJ)

OBSTETRICS/GYNECOLOGY

Nov.

1 Grand Rounds in Obstetrics and

8 Gynecology

15 4-5 p.m.—NJ Medical School, Newark

29 (*CMDNJ and AMNJ*)

7 Distinguished Lectures in Obstetrics and

Gynecology

8-10 p.m.—NJ Medical School, Newark

(*CMDNJ and AMNJ*)

7 Grand Rounds in Obstetrics and

14 Gynecology

21 3-5 p.m.—Rotates between CMDNJ

28 College Hospital, Newark Beth Israel

and St. Michael's Medical Centers,

Newark, St. Joseph's Hospital and

Medical Center, Paterson, and Jersey

City Medical Center

(*CMDNJ and AMNJ*)

14 Genetics

8-9 a.m.—Garden State Community

Hospital, Marlton

(*Garden State Community Hospital and AMNJ*)

Dec.

- 5 Lectures in Ob/Gyn**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

- 5 Combined Grand Rounds in Ob/Gyn**
12 3-5 p.m.—Rotates between College
19 Hospital, Newark Beth Israel Medical
26 Center, St. Michael's Medical Centers,
Newark, St. Joseph's Hospital and
Medical Center, Paterson and Jersey
City Medical Center
(*CMDNJ and AMNJ*)

- 6 Grand Rounds in Obstetrics and
Gynecology**
13 4-6 p.m.—College Hospital, Newark
20 (*CMDNJ and AMNJ*)
27

- 12 Pregnancy-Induced Hypertension**
8-9 a.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and
AMNJ*)

PATHOLOGY

Dec.

- 26 Clinical Pathology Conference**
9:30-11 a.m.—Bergen Pines County
Hospital, Paramus
(*Bergen Pines County Hospital and
AMNJ*)

PEDIATRICS

Nov.

- 6 Pediatric Blood Disorders**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 21 Neonatal Problems**
4 p.m.—Jersey City Medical Center
(*AMNJ*)

Dec.

- 4 Pediatric Respiratory Infections**
9 a.m.—Freehold Area Hospital
(*AMNJ*)

- 5 Neurological Problems of Infancy and
Childhood**
9-11 a.m.—Roosevelt Hospital,
Menlo Park
(*Middlesex Hospital, AAFP, and AMNJ*)

RADIOLOGY

Nov.

- 6 Diagnostic Ultra-sound—Abdominal**
8-9 a.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital and
AMNJ*)
- 20 Nuclear Medicine**
7 p.m.—Irvington General Hospital
(*AMNJ*)

GENERAL SURGERY

Nov.

- 5 Distinguished Lecture Series in
19 Surgery and Grand Rounds**
26 4:30-5:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 6 Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
- 28 Enteral Hyperalimentation with
Surgical Geriatric Patients**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

Dec.

- 3 Distinguished Lecture Series in
10 Surgery and Grand Rounds**
17 4:30-5:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 4 Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)

**SURGICAL SPECIALTIES (includes ENT,
Neurosurgery, Ophthalmology, Orthopedic,
Plastic, and Vascular Surgery)**

Nov.

- 16 Cardiovascular Surgery**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 19 Occlusive Cerebral Vascular Disease**
12:30-1:30 p.m.—West Hudson
Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 27 Basal Cell Carcinoma: Eyelid and
Eyebrow Reconstruction**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 28 Breast Disorders and Cancer of the Breast**
9:30-11:30 a.m.—Riverside Hospital,
Boonton
(*Dover General, Riverside, and St. Clare's
Hospitals*)

Dec.

- 18 Vascular Clamping Problems and
Solutions**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

MISCELLANEOUS

Nov.

- 1 Developmental Biology Course**
8 4-6 p.m.—Institute for Medical Research
15 Copewood St., Camden
29 (*Institute for Medical Research and
AMNJ*)

Dec.

- 4 Governmental Regulations on Practice
of Occupational Medicine**
1 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ*)
- 6 Developmental Biology**
13 4-6 p.m.—Institute for Medical
Research, Copewood St., Camden
(*Institute for Medical Research and
AMNJ*)
- 13 Common Athletic Injuries**
5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)

OBITUARIES

Dr. Nicholas A. Antonius

One of Essex County's senior members, Nicholas A. Antonius, M.D., of South Orange, died on August 17. A graduate of the University of Maryland School of Medicine in 1925, Dr. Antonius practiced internal medicine with special emphasis on cardiology in the Essex County area for many years. He had been affiliated with St. Michael's, St. Joseph's and Children's Hospital in Newark, St. Mary's Hospital in Orange, Clara Maass Memorial Hospital in Belleville, Morristown Medical Center, and St. Mary's Hospital in Hoboken. He was a Fellow of the American College of Chest Physicians and of the American College of Cardiology. Dr. Antonius had been a consultant in cardiology to the Crippled Children's Commission, the Newark Board of Education, the New Jersey Board of Child Welfare, and the Home for Cardiac Children in East Orange. He was a Fellow of the Academy of Medicine of New Jersey and a member of the board of trustees of the Essex County Heart Association. In 1974 Dr. Antonius was a recipient of MSNJ's Golden Merit Award, indicating 50 years of medical practice. Dr. Antonius was 81 years old at the time of his death.

Dr. Sydney Baxt

On August 23, Sydney J. Baxt, M.D., a member of our Passaic County component, died in Barnert Memorial Hospital. A native of New York City, born in 1911, Dr. Baxt was graduated from New York Medical College, class of 1938, and practiced general medicine in Paterson for over 40 years. He was affiliated with Paterson General Hospital, St. Joseph's Medical Center, Barnert Memorial, and the Memorial Hospital at Fair Lawn. He was a member of the American Academy of Family Physicians.

Dr. Louis J. Cheskin

One of Essex County's senior members, Louis J. Cheskin, M.D., of Maplewood, died on July 30. A graduate of Johns Hopkins University School of Medicine in 1930, Dr. Cheskin practiced internal medicine and cardiology for many years in Newark and Irvington. He was certified by the American Board of Internal Medicine, a Fellow of the American College of Cardiology. He had been affiliated with Martland Hospital and Newark Beth Israel Medical Center. During World War II he served in the medical department of the Army of the United States. Dr. Cheskin was 75 years old at the time of his death.

Dr. Frederick G. Dilger

Frederick G. Dilger, M.D., of Hackensack, died on August 15 at his home, at the grand age of 84. A native of England, he was a graduate of Fordham University School of Medicine, class of 1921. Dr. Dilger pursued a career in orthopedic surgery and was board certified in that specialty. He was a Fellow of the American College of Surgeons, of the International College of Surgeons, and of the American Academy of Orthopedic Surgeons. He had been affiliated with Holy Name Hospital in Teaneck, Bergen Pines County Hospital in Paramus, and St. Mary's Hospital in Hoboken. Dr. Dilger was a past president of his county medical society—Bergen. In 1971, he was a recipient of MSNJ's Golden Merit Award, indicating 50 years of practice. Dr. Dilger was active in civic affairs and had been a member of the State of New Jersey Crippled Children's Commission.

Dr. Leon C. Edwards

A member of our Somerset County Medical Society, Leon C. Edwards, M.D., died tragically in Wisconsin on

July 29 when the plane he was piloting crashed as he was attempting an emergency landing. Born in 1924 and graduated from Harvard Medical College in 1955, Dr. Edwards pursued graduate surgical training there and at Boston City Hospital, and practiced general and vascular surgery in the Somerville area. A former director of surgical research at Ethicon, Inc., in Bridgewater, he currently was on the surgical staff at Somerset Hospital and Raritan Valley Hospital in Green Brook. He had been a research fellow at Sears Surgical Laboratory in Boston and published his findings on the biology of inflammation and repair. He was a diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. Dr. Edwards was active in Medical Society affairs and at the time of his death was a member of MSNJ's Committee on Long Range Planning and Development. He also was licensed in Maine and Vermont and was attending surgeon at the Mount Desert Island Hospital in Bar Harbor. He formerly was a navigator in the Air Force and also served as surgeon to the Air Forces.

Dr. Thomas M. Kain, Sr.

One of Camden County's senior members, Thomas M. Kain, Sr., M.D., died on August 4 at Cooper Medical Center where he had been a member of the staff in the department of medicine from 1913 until his retirement in 1960. He was a graduate of Jefferson Medical College, class of 1912. He also was affiliated with Our Lady of Lourdes Hospital in Camden, Zurbrugg Memorial Hospital in Riverside, and Lakeland Hospital. He was a past-president of the Camden County Medical Society and was active in other physicians' organizations. Dr. Kain was board certified in internal medicine and a member of the American College of Physicians. Two of his three

sons, Thomas M. Kain, Jr., and Eugene H. Kain, are practicing physicians in Pennsauken. Dr. Kain was 92 years of age at the time of his death.

Dr. Maxwell Klausner

Maxwell Klausner, M.D., of Toms River, was killed on August 25 on the Garden State Parkway while repairing a flat tire on his car. The driver of the vehicle which struck Dr. Klausner was arrested on a drunken driving charge. A graduate of New York Medical College in 1960, Dr. Klausner took a residency in medicine at Newark Beth Israel Medical Center in Newark and had practiced that specialty first in Newark and more recently in Toms River. He was affiliated with Newark Beth Israel Medical Center and Point Pleasant Hospital. Dr. Klausner was only 45 years old at the time of his death.

Dr. James R. Lomauro

At the grand age of 80, James R. Lomauro, M.D., of Toms River died at his home on July 9. A native of Italy, Dr. Lomauro was graduated from Cornell University College of Medicine in 1924 and pursued a career in general medicine, with special interest in obstetrics and gynecology. He had practiced for many years in Passaic before retirement and had been affiliated with St. Mary's and Passaic General Hospitals. He had been a charter member of the New Jersey Society of Obstetricians and Gynecologists, and was a member of the Academy of Medicine of New Jersey.

Dr. Joseph A. Miller

A member of the Essex County Medical Society, Joseph A. Miller, M.D., died on July 23. Born at the turn of the century, Dr. Miller was graduated from the College of Physicians and Surgeons of Columbia University in 1925 and pursued a career in otolaryngology. He was board certified in that specialty, a Fellow of the American College of Surgeons and of the American Academy of Ophthalmologists and Otolaryngologists. He had been affiliated with Newark Eye and Ear Infirmary and Columbus Hospital in Newark, East Orange General, and Clara Maass Memorial Hospital in Belleville. Dr. Miller was a 1975 recipient of MSNJ's Golden Merit Award, indicating 50 years of active practice.

Dr. J. Edwin Obert

On August 8, J. Edwin Obert, M.D., died at his home in North Palm Beach, Florida. Born in 1902, in Asbury Park, Dr. Obert earned his medical degree from New York University Medical School in 1928 and established a practice in New Egypt and later in Metedeconk. He was a member of the surgical staff at Jersey Shore Medical Center and had been chief of surgery at the Point Pleasant Hospital. Dr. Obert retired to Florida in 1956 and directed his activities to civic affairs, such as the Lion's Foundation for the Blind, the American Red Cross, and others. He had been a member of the International College of Surgeons, the Academy of Medicine of New Jersey, and the Ocean County Medical Society.

Dr. Albert Oppenheimer

A member of our Burlington County component, Albert Oppenheimer, M.D., died on August 7. A native of Germany, Dr. Oppenheimer earned his doctorate of medicine from Frankfurt University College of Medicine in 1924 and pursued graduate training in radiology becoming board certified in that specialty. He received his New Jersey license in 1951 and established a practice in Mount Holly. He was a Fellow of the American College of Radiology and had been affiliated with the Burlington County Memorial Hospital in Mount Holly. Dr. Oppenheimer was 79 years old at the time of his death and was residing in Maplewood.

Dr. Thomas M. Rein

A member of our Middlesex County component, Thomas M. Rein, M.D., of New Brunswick, died on August 19. A native of New Jersey, born in 1913, Dr. Rein earned his medical degree from the University of Glasgow in 1950 and returned to his native land for the practice of general medicine. He was affiliated with St. Peter's and Middlesex Hospitals in New Brunswick and had been affiliated also with the medical department of Johnson and Johnson. Dr. Rein served in the artillery with the Army of the United States during World War II.

Dr. Friedrich Rothenberg

On July 30, Friedrich Rothenberg, M.D., died at the Daughters of Miriam

Center for the Aged in Clifton where he had been a full-time member of the staff since 1948. Born in Berlin, Germany, Dr. Rothenberg received his medical education at Friedrich Wilhelm University, class of 1913, and was an officer in the German army in World War I. He practiced in Berlin until Nazi persecution forced him to flee in 1939. After being interned for nine months as an enemy alien, Dr. Rothenberg came to Paterson in 1940 and received his license to practice medicine in New Jersey in 1945. He had been affiliated also with Barnert Memorial, Paterson General, and St. Joseph's Hospital in Paterson. Dr. Rothenberg was 90 years old at the time of his death.

Dr. Gaetano Ruggieri

At the untimely age of 53, Gaetano Ruggieri, M.D., died in Dover General Hospital on July 14 following an acute myocardial infarction. Born in Italy, Dr. Ruggieri was graduated from the medical school of the University of Pavia in 1954. He came to the United States the following year for further training, and completed a residency in psychiatry at Greystone Park State Hospital. Dr. Ruggieri established a psychiatric practice in Landing, and was affiliated with Greystone Park State Hospital, Newton Memorial, Dover General, Franklin, and the Alexander Linn Hospitals. Dr. Ruggieri was a member of the American Psychiatric Association and its New Jersey affiliate, and of the Morris County Medical Society.

Dr. Andrew K. Ruotolo

On August 8, Andrew K. Ruotolo, M.D., a member of our Essex County component, died at his home. Born in 1926 and graduated from Cornell University Medical School, class of 1948, Dr. Ruotolo pursued a career in psychiatry after completing a residency at the Veterans Administration in Montrose, New York. Prior to that he served for four years in the medical department of the United States Navy. Dr. Ruotolo had been affiliated with St. Michael's and Martland Medical Centers.

Dr. William C. Wilentz

A former member of the Board of Trustees of the Medical Society of New Jersey, William C. Wilentz, M.D., died on August 12. A native of Perth Amboy,

born in 1900, Dr. Wilentz earned his medical degree at Jefferson Medical College in 1923. He pursued a career in urological surgery and was affiliated with Roosevelt Hospital in Metuchen and Perth Amboy Hospital. At the latter hospital he also practiced industrial medicine and was a consultant in forensic medicine. Dr. Wilentz served terms both as president of the staff and chief of staff at Perth Amboy Hospital, and had been chief medical examiner for Middlesex County. He held membership on

many civic boards and was the author of numerous articles on industrial medicine and medical/legal matters. In 1973 Dr. Wilentz was a recipient of MSNJ's Golden Merit Award, indicating 50 years in active practice.

Dr. Harry Wolfson

Harry Wolfson, M.D., died at St. Joseph's Medical Center in Paterson on August 9. A native of Canada, Dr. Wolfson was graduated from the University of Toronto Medical College in

1925 and moved to New Jersey almost immediately. He was a general surgeon and had been on the staff at St. Joseph's Medical Center. Dr. Wolfson was a Fellow of the American College of Surgeons, and was a past president of the Passaic County Medical Society. During World War II, Dr. Wolfson served in the U.S. Navy. He was a 1975 recipient of MSNJ's Golden Merit Award, indicating 50 years of practice. Dr. Wolfson was 78 years old at the time of his death.

BOOK REVIEWS

Boswell's Clap and Other Essays: Medical Analyses of Literary Men's Afflictions

William B. Ober, M.D., Carbondale, IL, Southern Illinois University Press, 1979, Pp. 291. Illustrated. (\$17.50)

James Boswell (1740-1795), best known for his biography of lexicographer Samuel Johnson, was a Scottish lawyer of lusty disposition. In his diary and letters he recorded numerous extramarital dalliances which resulted in nineteen episodes of "clap." Boswell got his first Neisserian infection at age 19, the last when he was 51. One paramour, an honest whore, returned the money upon demand when notified of his infirmity! Sexually vigorous through life, urethral strictures and obstructive uropathy finally sent him to the grave.

The ten essays in this volume range from a chronicle of Boswell's repeated attacks of gonorrhea to the careers of three famous physician-writers: John Keats, who died young of tuberculosis and used opium for relief; Anton Chekhov, also tubercular, who mocked

doctors and others in his whimsical prose; and William Carlos Williams, New Jersey's poet laureate who drew realistic themes from his daily work as a pediatrician.

D. H. Lawrence, a strange man who wrote on strange topics, suffered from pulmonary tuberculosis and psychosexual qualms. In "Lady Chatterley's *What?*", Dr. Ober discusses Lawrence's life and *oeuvres* in erudite fashion. (For those interested in what happened later, I recommend *Lady Chatterley's Second Lover*, a novel by Ted Mark published by Manor Books, New York City, in 1976. It tells of Connie's infatuation with Anthony Mudstick, a cultural anthropologist.)

William Ober, pathologist and director of laboratories, Hackensack Hospital and visiting Professor of Pathology, New Jersey College of Medicine, Newark, has gathered the chapters in this book from his articles which originally appeared in medical journals. With their scholarly preface and notes they provide a parade of human genius, madness, bathos, and pathos. Several of them, such as the essays on the masochism of Algernon Swinburne and the sexual

problems of the 17th-century Earl of Rochester, remind us of the dictum of W. Somerset Maugham: "The mystic sees the ineffable, and the psychopathologist the unspeakable."

Fred B. Rogers, M.D.

Early Physicians of Northeastern Bergen County

Michael A. Nevins, M.D. Spring Valley, New York, The Town House Press, 1979. Pp. 60. Illustrated. (No price given)

Dr. Nevins, of River Vale, has compiled a commendable account of regional medical history. Its focus is on physicians who practiced in the Pascack and Upper Northern Valleys of Bergen County before 1920. Since early doctors ranged over a wide territory, the author includes biographical material concerning physicians in adjacent areas. A photograph of Dr. John C. Dingman (1881-1971) making his rounds on horse-

back evoked nostalgia because my father, Dr. Lawrence H. Rogers, served a *locum tenens* in Spring Valley for him during the summer of 1910. Dad long recalled the rural charm of that place and Dr. Dingman's special skill in treating fractures.

Bergen County was thinly populated well into the 1900's. Originally settled by Dutch, Huguenot, and other immigrants, the first medical man of record was Dr. Johannis Van Emburgh who practiced in Hackensack from about 1686 to 1709. Dr. Joseph Sackett, Jr., of Paramus, became one of the founding members of the Medical Society of New Jersey in 1766. Bergen was the fifth county to organize a component society (1818). Dr. Charles Hasbrouck, of Hackensack, was the first Bergen physician to become president of the state medical society in 1871. Later, Dr. Samuel Alexander, of Park Ridge, headed that organization in 1945.

Chapters in this book discuss the first doctors, mid-nineteenth and early twentieth-century physicians, and the establishment of hospitals. Vignettes of Drs. Henry C. Neer (1838-1911), a versatile man who became the first mayor of Park Ridge; Simeon J. Zabriskie (1830-1915), one of a medical family who practiced in Westwood; George Max Levitas, who succeeded Zabriskie in practice; Theodore E. Townsend (1870-1930), owner of the first automobile in Westwood; Joseph A. Moenig (1875-1970) whose initial office was a converted chicken coop; and David Goldberg (1896-1966), for whom the medical library at Pascack Valley Hospital is named, are included. Two others described are Drs. William L. Vroom (1866-1966), beloved long-time practitioner in Ridgewood, and Dinshah P. Ghadiali (1873-1966) of Hillsdale, a pioneer aviator, inventor and yoga exponent. Contributions by many able, dedicated physicians are chronicled here. Having lived in heroic times, they are subjects of inspiring and, often, amusing anecdotes. All are gone now, though the fruits of their labors survive.

Fred B. Rogers, M.D.

Birth of a Family. The New Role of the Father in Child-birth.

Nathan Cabot Hale. New York, Doubleday, 1979. Pp. 197. Illustrated. (\$7.95)

The author says that "this book is a book about childbirth from the father's point of view. It has been written by a man for men. It is not a medical textbook and has not been written by a medical doctor. It is a book written about things that are common to all ordinary men in the process of childbirth. It is a book about the seldom respected, sadly neglected instinct of fatherhood."

I was pleased to review this book because the father's role during childbirth is extremely important, and information related to this matter is useful, especially in convincing undecided men of how vital their part is to the mother, child, and themselves.

Unfortunately, this author, as most of the lay authors who have written about "natural childbirth," has the attitude that it is fashionable to attack the medical profession, and we usually are presented as a group of materialistic, insensitive, arrogant people whose main concern is economic profit. These authors present themselves as protectors of the people, and carriers of the truth.

At the beginning the author states he wrote this book in "the face of ignorance, arrogance, and the material concepts of a certain junta of the world's medical profession." In addition to that statement the author on several occasions made prejudicial remarks such as the explanation that episiotomy is not necessary; however, "a large incision is routinely given for the following activity and convenience of the physician." Circumcision is "routinely done by the mechanistic physician, when he can obtain the consent of the parents (and he always urges them to consent)." Anyone with some knowledge of modern obstetrics realizes the inaccuracy of these remarks.

Unfortunately, books that create this distorted vision of modern obstetrical practice only produce mistrust, lack of understanding, and discord, between doctors and potential parents.

The author's intention is to prove that there is a fatherly instinct and he intends to help men find that instinct. In addition, he advocates the value of the natural and non-violent approach to childhood with emphasis on the father's role during childbirth and the value of the Leboyer's non-violent birth. This book is related to his experience with three couples during childbirth who were supposed to have "a pure, natural childbirth experience." It is interesting to notice that the first patient was delivered under spinal anesthesia, the second, under epidural anesthesia, had a forcep delivery and episiotomy, and the last patient required analgesics. Nevertheless, the author disregards these facts and insists upon the "uselessness" of these procedures.

The book is written pompously. Phrases such as "the forces of nature are vast and powerful beyond our comprehension, and the conception, embryonic growth, and birth of a baby are as much a 'cosmic event' as any of the acts of creation that take place in our galaxy, but we humans often fail to recognize that birth is a part of this whole continuum" are found frequently.

This book is a book of unnecessary information rather than a guide for potential fathers. I found it very interesting that everyone is called by his first name with the exception of "his friend the obstetrician"; when referring to him full name, working location, and degrees are given. His description of this doctor as a human being, and a practitioner of obstetrics implies to the reader that he is the exception to the rule rather than the standard physician.

Despite this negative review, books dealing with this important subject should be encouraged. Hopefully, non-medical authors will give a more realistic, knowledgeable, and less prejudicial view of pregnancy.

Marco Antonio Pelosi, M.D.

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Total Parenteral Nutrition

G. J. Paul, M.D.

Myocardial Abscess

M. Aslam, M.D., et al.

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Cost Containment and the Voluntary Effort.

For its almost 4,000,000 subscribers, Blue Shield of New Jersey extends its appreciation to the 8,900 participating physicians who provide service benefits to eligible members.

This program demonstrates that a voluntary effort can work. Service benefits **is** cost containment. And, it's the best way physicians and Blue Shield can work together to halt rising medical care costs.

For **your** contribution, in the form of service benefits, we thank you.



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New Jersey

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Cover is picture of Dr. Joseph H. Kler of New Brunswick wearing the dress of the Colonial days and seated at a desk in the Vander Veer Office (see Commentary, page 814 this issue).

Note Dates
and Location

214th Annual Meeting
May 10-13, 1980
Meadowlands Hilton, Secaucus

MEDICAL CONSULTING & SUPPLY GROUP, INC.

An Open Letter to All Doctors On Cost Containment

In a time of imminent National Health Insurance, PSRO reviews, and Diagnostic Related Grouping reimbursement, physicians must become better businessmen. By applying the principles of group purchasing, physicians can take advantage of a method of cost containment which will not compromise quality care to the patient.

Group purchasing has been in existence for many years in the hospital setting. Many groups, such as hospital associations that have saved large sums of money, were formed to counter cutbacks in reimbursement from the major third party payors.

Medical Consulting & Supply Group is the first group purchasing effort in New Jersey for doctors' offices. Originally, eleven doctors in Bergen County with large practices volunteered to reduce their expenses through a group effort. Minimum and maximum inventory levels were set, so offices would be stocked at a two week level. This created the most desirable situation in materials management—low inventory and low prices.

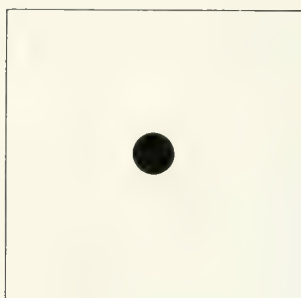
The Group now consists of 67 offices. As the group has increased, prices have decreased. Items are stored in a warehouse centrally located in Lodi, New Jersey, and are delivered in the Group's own truck, thereby minimizing expenses for all deliveries.

Doctors are both managers of their businesses and masters of their skills. However, most time is spent perfecting skills rather than tending to business. Participating in the Group provides each doctor with a new management tool for the office that has proven in all cases to save money.

For information, please write or call:

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A blood clot the size of this dot can cause a Heart Attack.



Or a stroke.

Every year, thousands die because of a blood clot. Thousands more become disabled, some permanently.

What's being done to stop it?

Plenty.

We're the American Heart Association. We're giving scientists the chance to find out more about blood clots.

How to detect them. How to treat them. How to keep them from happening.

We're fighting hard. With new drugs. New kinds of treatment. Better ways to help heart attack and stroke victims return to a normal life.

And it's only a part of the total war we're waging against the number one cause of death in this country: heart disease and stroke.

But we can't fight without your money. When the Heart Association volunteer asks for your dollars, be generous.

The blood clot is small, the problem is enormous.

The American Heart Association 

WE'RE FIGHTING FOR YOUR LIFE

- Bendectin continues to be the only product indicated exclusively for morning sickness — nothing else.
- Convenient bedtime dosage.
- Works in the morning when she needs it most.

Bendectin[®]

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION

Nausea and vomiting of pregnancy.

PRECAUTIONS

Because of potential drowsiness, Bendectin should be prescribed with caution for patients who must drive automobiles or operate machinery. Studies in rats and rabbits have revealed no suggestion of drug-induced fetal abnormalities at doses of Bendectin up to 90 times the maximum human dose. In addition, several epidemiologic studies in women who received Bendectin during pregnancy have shown that the incidence of birth defects in their offspring is no higher than in women not taking the drug during pregnancy. Nevertheless, like all drugs considered for use during pregnancy, particularly during the first trimester, Bendectin should be used only when clearly needed.

ADVERSE REACTIONS

The adverse reactions that may occur are those of the individual ingredients. Doxylamine succinate may cause drowsiness, vertigo, nervousness, epigastric pain, headache, palpitation, diarrhea, disorientation, or irritability.

Pyridoxine hydrochloride is a vitamin that is generally recognized as having no adverse effects.

DOSAGE AND ADMINISTRATION

2 Bendectin tablets at bedtime. In severe cases or when nausea occurs during the day: 1 additional Bendectin tablet in the morning and another in midafternoon.

Product Information as of January, 1978

References:

1. Meyer, C.: American Folk Medicine. Scarborough, New York, Plum Books — New American Library, 1975, p. 208.
2. Data on file, MERRELL-NATIONAL LABORATORIES
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MNQ-013

1830: A decoction of columbo root and peppermint 3 or 4 times a day should be taken for the sickness to which pregnant females are commonly subject.¹

TODAY: Clinical studies show statistically proven efficacy for morning sickness of pregnancy with delayed-release Bendectin tablets.²



In morning sickness
confidence begins with
Bendectin®

Each tablet contains doxylamine succinate 10 mg,
pyridoxine hydrochloride 10 mg.



trusted alternative to nausea and vomiting of pregnancy
For prescribing information see opposite page.

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CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

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Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

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Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

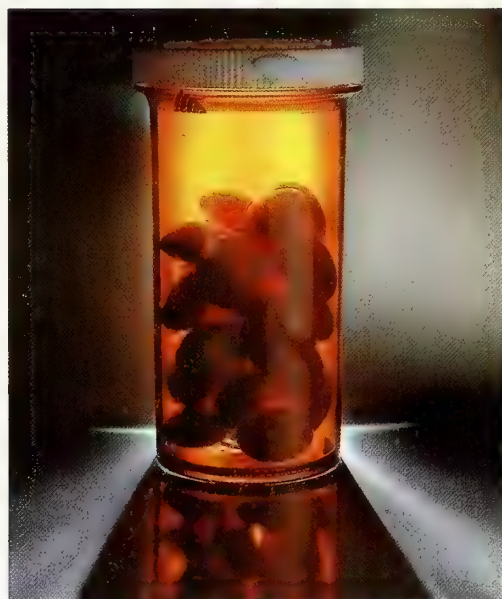
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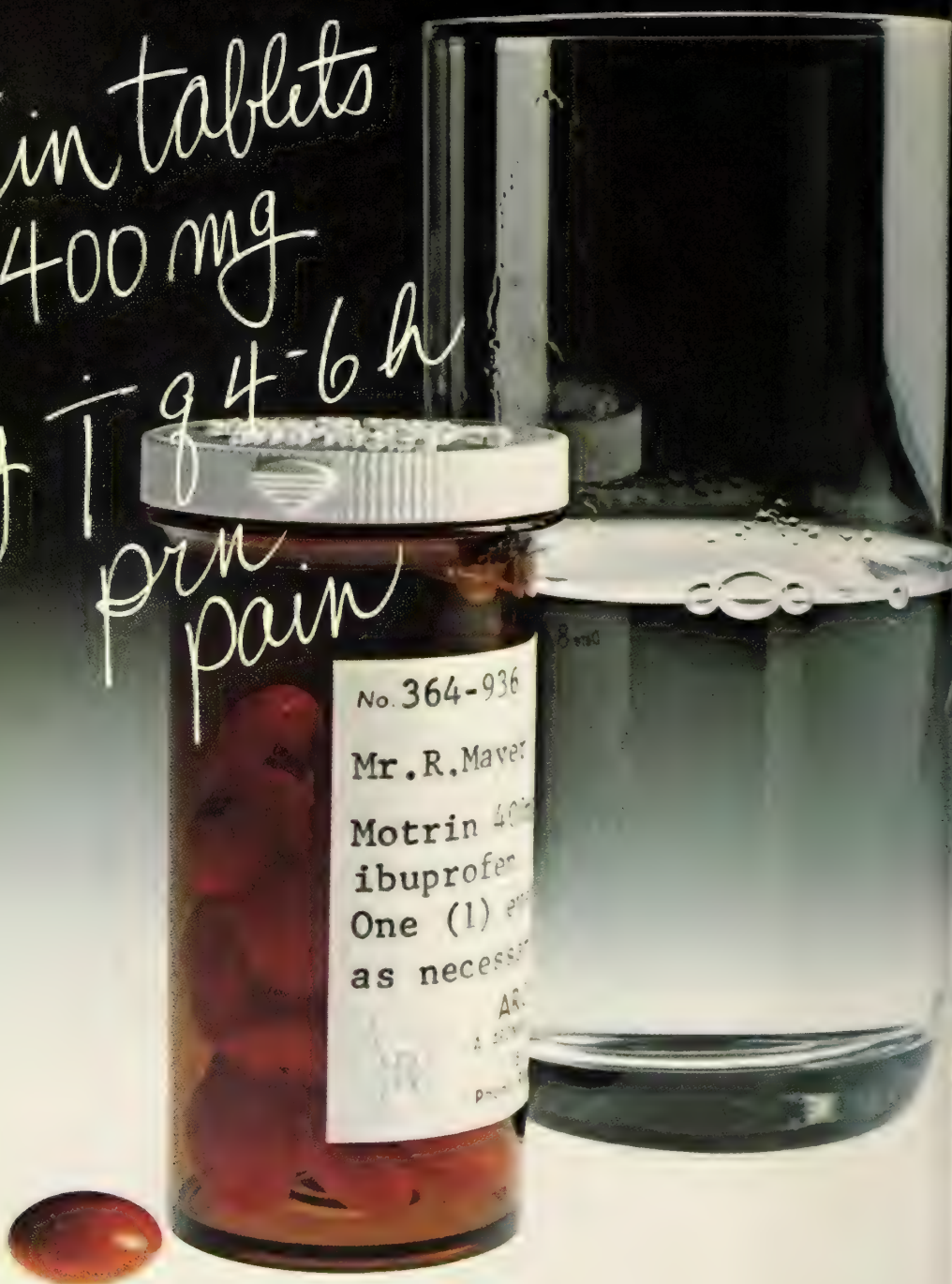
The Upjohn Company
announces
a new
indication for
Motrin[®]
(ibuprofen)



A well-tolerated, nonnarcotic prescription for pain

Motrin tablets
400 mg

Sig T q 4-6 h
prn
pain



Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
 - Rapid analgesic action • Indicated in acute and chronic pain
 - Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.
- Please turn the page for a brief summary of prescribing information.



Motrin[®] (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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containing methylidopa and hydrochlorothiazide

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Featuring Rule 4:21: Panel Hearings

The *Professional Liability Commentary* prepared by the Department of Liability Control, will be a monthly feature designed to inform members of the Medical Society of New Jersey of mutual concerns and to provide general information regarding professional liability. Brief commentaries will include medicolegal aspects of health care, state and national statistics, discussion of defensible and indefensible claims, particular issues as they relate to medical specialties, and information on claims activity within the state as reported by the two major insurers of physicians, the Medical Inter-Insurance Exchange of New Jersey (MIENJ) and the New Jersey Medical Malpractice Reinsurance Association (NJMMRA).

It is hoped that this monthly commentary will heighten physician awareness of medicolegal problems in the practice of medicine and aid in the reduction of claims and the improvement of health care.

RULE 4:21: PANEL HEARINGS

An important rule governing the practice and procedure in the administration of all the courts in New Jersey was adopted on July 24, 1978, and became effective September 11, 1978. This rule concerns itself with professional liability claims against members of the medical profession. Prior to this rule, panels were a voluntary procedure. Rule 4:21 makes the panel mandatory and has as its purpose: (1) to discourage baseless actions; (2) to encourage settlement of claims based on reasonable medical probability; (3) to monitor efficiently these cases through the court; and (4) to assist the early disposition of medical malpractice actions.

Once a malpractice action has been assigned a special identifying letter, the Assignment Judge delegates the case to a judge who previously has been designated to handle all medical malpractice cases in his vicinage. This judge will preside at all pretrial discovery proceedings, the pretrial conference and the panel hearing, but shall not preside at the trial of the action.

A pretrial conference is held not later than twelve (12) months following the service of process upon the defendants for the purpose of submitting a claim to a panel hearing. The panel consists of the judge as chairperson, a physician and an attorney. The Administrative Director of the Courts selects the physician from a panel designated by the Medical Society of New Jersey or the New Jersey Society of Osteopathic Physicians and Surgeons. The attorney is selected from a panel of attorneys with trial experience designated by the Supreme Court. Where practical, the physician panelist shall be a practitioner in the specialty involved in the case. Procedures are available for either party to the claim to file written objections to the designation of the physician or attorney.

The hearings are informal and held without a stenographic record. Statements or opinions made in the course of the hearing may not be admissible as evidence at a trial of the action. The parties present their factual and legal contentions. Witnesses and parties called to testify may be cross-examined and the judge may issue subpoenas and compel compliance.

Panel members are charged to hear the arguments of both parties in order to ascertain the facts and determine if the claim is based on reasonable medical probability.

Panelists are not intended to function in the role of an expert witness and should refrain from voluntarily contributing information that could possibly damage or assist either the plaintiff's or the defendant's presentation. The function of an expert witness is to provide expertise to support a position. The function of the panelist is to pass judgment on the facts as they are presented.

The panelist may ask questions to clarify a point but should refrain from offering opinions. After the parties have formally presented their evidence, the panel will privately discuss the evidence. The physician panelist will have the opportunity to render his professional opinion based on the evidence presented.

The findings of the panel are confidential and may not be used in any proceedings other than the trial of the action. Should the findings be unanimous, they shall be admissible in evidence at a trial upon request of any party to the hearing. The findings, however, are not binding upon the jury or upon the judge. If the panel findings are not unanimous they cannot be used in evidence. The parties may accept the findings of the panel and settle the claims involved, or they may discontinue further litigation. If the parties to the litigation request, the panel may fix damages.

The organization and implementation of Rule 4:21 became operative by late April of this year. A survey of 113 files at the end of July, conducted by the Administrative Director of the Courts, revealed approximately 77 files with no final disposition, 26 files settled prior to judgment of the panel, and two files which proceeded to trial. Continued collection of data by the Administrative Director of the Courts will aid in future determination of the strengths and weaknesses of Rule 4:21. Until such time, it is difficult to evaluate the effectiveness of Rule 4:21.

DID YOU KNOW . . .

The first recorded medical liability case was February 1377. The physician was held liable for improper treatment

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

of a leg injury (*Hill v. Cheyndnt, London Guild Hall Plea and Memoranda Rolls*). The Medical Inter-Insurance Exchange of New Jersey began in February 1977, some 600 years later . . . The national average for plaintiff attorneys' fees ranges from 25 to 50 percent. New Jersey has established a "contingent fee arrangement" for legal services to plaintiffs based on the following: 50 percent on the first \$1000 recovered, 40 percent on the next \$2000 recovered, 33-1/3 percent on the next \$47,000 recovered, 25 percent on the next \$50,000 recovered, 20 percent on the next \$150,000 recovered, 10 percent on any amount over \$250,000. How is your math on a \$100,000 claim? . . .

Contrary to general opinion that juries in professional liability suits are "pro plaintiff," current statistics indicate that for every 100 claims reported 16 go to trial and nine percent of these end in favor of the plaintiff or 1.4 of every 100 claims reported, (*NAIC Report*) . . . Professionally sponsored companies represent 39.9 percent of the total providers of professional liability insurance (John Linster, *Best's Review*, 2/79 . . .

Over 85,000 physicians currently are insured through 21 physician-owned companies writing professional liability insurance (Alabama, Arizona, California, Northern California, Southern California, Florida, Illinois, Maine, Maryland, Michigan, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas and Utah).

DEPARTMENT ACTIVITIES

James E. George, M.D., J.D., Director of the Department of Professional Liability Control of the Medical Society of

New Jersey, has conducted medicolegal seminars for two specialty societies: Anesthesiology and Obstetrics/Gynecology. Letters have been sent to specialty society presidents informing them that the Department of Professional Liability Control seminar service is available to assist them in planning and presenting seminars tailored to their specialty needs.

The department of liability control has been given permission to grant category 1 AMA credit for attendance at medicolegal seminars.

Many members of the Society have raised questions about the subject of patient informed consent. In an effort to generate informed consent materials to assist New Jersey physicians, the Department has mailed examples of consent forms to specialty societies for their perusal, comments, recommendations and general input into the development of such materials.

PHYSICIAN ALERT: SYNTHETIC HAIR TRANSPLANTS

Several incidents and claims have come to the attention of the Department of Liability Control involving synthetic hair transplant.

If you are a physician who works for a synthetic hair transplant facility we urge you to consider your added exposure to claims for malpractice and to insist that the clinic carry its own malpractice insurance and name you as an additional insured.

Questions and/or correspondence should be directed to the Department of Professional Liability Control, MSNJ, 2 Princess Road, Lawrenceville 08648.

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physician takes the necessary extra steps, for many drugs the pharmacist must substitute a lower-cost brand name of that drug or a lower-cost "equivalent" generic drug contained in the latest list of interchangeable drug products published by the Drug Utilization Review Council.

The law states:

- NOTE:

- R
- ₂

MD

The decisions the physician must make

The physician should acquaint himself with the newly mandated prescription form illustrated on the preceding page. This form requires a distinct change from the way he has previously written prescriptions.

There are now *two* spaces for the prescriber's initials. The prescription will be filled generically or with another brand name of that drug unless the physician initials the space stating "do not substitute." When transmitting an oral prescription, the physician must explicitly state that there shall be no substitution. Only by taking these

measures can he ensure that the brand-name drug he prescribes will actually be dispensed.

If the physician elects to permit substitution, he must indicate this by initialing the space marked "substitution permissible." The drug actually dispensed must be of lower cost and must be contained in the latest published list of interchangeable drug products. Substitutions shall not be made unless cost savings are passed on to the consumer.

Please refer to a copy of the law for complete details.

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There is no substitute for research.

Standards of Care and Professional Liability

Medical malpractice or negligence generally is defined as deviation from accepted standards of care resulting in injury to a patient. One of the most difficult problems of proof in medical malpractice cases is that of establishing the standard of care, deviation from which allegedly has resulted in negligence.

In establishing the standard of care in a particular case, many sources of information are utilized. These include textbooks, articles from the medical literature, the opinions of expert medical witnesses, as well as pronouncements made by hospital accrediting organizations, such as the Joint Committee of Accreditation of Hospitals, and the hospital bylaws, rules, and regulations. The thrust of the plaintiff's case is to try to convince the jury that only one appropriate method existed to solve the patient's problem and that the defendant physician deviated from accepted standards of care in not following this method.

The "game" of medical professional liability essentially boils down to one of persuading the jury. The plaintiff and his attorney increasingly are able to obtain an expert physician's report from an expanding number of sources. Among these sources are the traditional expert from New York City or Philadelphia, interstate medicolegal consulting services for plaintiffs, and faculty members of university medical centers. These sources of medical expertise are more than willing to provide service to the plaintiff and his attorney and aggressively to represent the plaintiff's position.

These medical experts are contributing to a dilemma for the medical profession. Physicians are being pushed into the position of being a guarantor of health and cure. This is a patently impossible situation and one which neither God nor man intended. This guarantor trend probably will become more aggravated in view of the Federal Trade Commission's encouragement of physician advertising, the medical, legal and social repercussions of which will be great.

What can be done to ameliorate the medicolegal problem of defining the standards of physician care? There are three things which might serve to diminish this problem for the medical profession. First, medical schools and postgraduate medical education programs should concentrate more on the practical aspects of medical care, rather than pursuing relatively rare medical entities. This change in emphasis probably would result in a greater number of basically skilled practitioners. There is no evidence that a shift toward emphasizing the practical instead of the esoteric would prevent some physicians from pursuing their own specialty and subspecialty inclinations. One might speculate that the current shift toward primary care will accomplish this change by the normal medical evolutionary process.

Second, courses in English and semantics should be given to physicians who contribute to the medical literature. Too

many medical authors attempt to portray clinical certainty in the articles they write. The unfortunate result of such a pursuit of certainty is to provide the plaintiff and his attorney with abundant materials in the medical literature which tend to paint a clear and absolute standard of care. A larger element of caution and humility in the medical literature should go a long way toward portraying medicine in a more realistic light.

Third, the current "CME mania" has created problems for physicians. The desire to certify physician competence has resulted in a CME bureaucracy of immense proportions, great cost, and no proved or measurable utility in increasing physician competence. No doubt we all are familiar with the medical school saying that the best students do not always make the best doctors. The same aphorism seems to apply in the area of physician continuing medical education. An unavoidable side effect of CME activity is to make a physician feel more clinically secure after taking such courses. This post-CME physician may tend to visualize his practice in a more black and white fashion and also may have the inclination to testify as an expert witness for the plaintiff.

What can be done about the problems listed above? There is little that organized medicine can do. However, we as individual physicians can strive for honesty and objectivity in our dealings with our patients and our fellow physicians. If we are not certain about what has transpired regarding the patient's illness or treatment, we should not be reluctant to state our uncertainty and the reasons why. This is not to say that physicians should be indecisive. Physicians should not be hesitant to acknowledge the mystery of illness which is present in many of the patients we treat. Such honesty will be appreciated by patients and their families, other health professionals, and most especially by physician defendants who have been accused of professional negligence.

The irony of the dilemma of standards of care is that the same rigorous approach which the courts have applied to medicine has not yet been applied to the legal profession. The simple fact is that the great majority of lawyers would be unable professionally to adhere to the same rigid standards of timeliness and competence now being required of the medical profession. Perhaps things will change as the public holds lawyers more accountable for their professional conduct. Let us hope that lawyers and judges gradually will begin to see that, although to err is human, it is not always a compensable event. Until then, physicians who comment on standards of medical care should attempt to be as fair and objective with their fellow physician as they would want him to be with them. This mutual understanding, coupled with meticulous record keeping and good patient rapport, should get us through the troubled times in which we practice.

James E. George, M.D., J.D.

We Are Seventy-Five

Having commenced publication in September, 1904, *The Journal* of the Medical Society of New Jersey is now seventy-five years old. In effect, it replaced the *Transactions* of the Society, the original printed record of the proceedings of the organization from the time of its formation at Duff's Tavern in New Brunswick on June 27, 1766.

The *Transactions*, printed once a year, after the annual general meeting of the Medical Society of New Jersey, was renamed *The Journal* and became a monthly publication in order to meet several needs. According to Editor, Richard Cole Newton, "it (*The Journal*) is the mouthpiece of the State Society and asks the good will and kindly attention of every physician, sanitarian and public man in the State."

The purposes of the change from an annual volume to monthly installations were several:

- To combat the "lack of interest amongst the younger men in the State Society."
- To gain and sustain interest of the membership in "worthy projects in which the Society became deeply interested at some annual gathering."
- To deal with public and private events "which stirred the times and could not await the once-a-year report of committees."
- To gain new members and to permit members to "be

better acquainted with each other" and to be "better informed in regard to current events in legislation, hygiene and education."

- To cope with the "enormous advance in the direction of scientific medicine" through the publication of the "high grade of papers and discussions at its annual meetings."
- To make a record of the "great amount of excellent literary and scientific medical material (which) goes to waste in our State every year."
- To collect and publish "clinical histories from the various hospitals, asylums and sanitariums throughout the State."
- "To get better hospital reports and to have them properly filed in libraries that shall be accessible to all students and statisticians."

The editorial and management staff of *The Journal* is attempting to maintain the original tradition of the *Transactions* and *The Journal* and to improve the "organ" of the Society. In order to fulfill these aims we restate an invitation from our first editor:

"Friendly criticism is earnestly invited and reasonable suggestions will be, so far as practicable, carried out."

A.K.

Stress—Good or Bad?

A 54-year-old, very successful architect, who prided himself on his work ethic, which included as many as five business meetings per week, developed transient numbness of an upper extremity, recurrent transient dysarthria and aphasia, and mild truncal ataxia. Heavy smoking, excessive alcohol consumption, and rare vacations characterized his life style, and non-insulin-dependent diabetes was his major medical problem. Transcervical and selective cerebral angiography disclosed a complete occlusion of the right internal carotid artery and a ragged atherosclerotic left internal carotid—a picture one might expect in an octogenarian.

To this man, stress is "the name of the game." Stress undoubtedly made him aggressive, alert, and successful, but was it good stress? What role did stress play, along with unknown genetic factors and chemical diabetes, in the production of rampant vascular aging?

Whether stressful stimuli are external or internal in origin, the body reacts in a predictable fashion with biochemical, physical (functional), and emotional changes. "Bad stress" usually is felt to be associated with unhappy or unwanted events—death of a friend or relative, a bad business deal, an unexpected operative or postoperative complication. "Good stress"—added work responsibility associated with a promotion, 70-hour work weeks, or appointment to the tenth hospital staff committee—is thought by many to be benign and even desirable. But is it?

Although the cerebral cortex at the highest level can distinguish between "good" and "bad" stress, the body

below that level does not seem to do so. Thus, hypertension, tachycardia, hyperglycemia, hyperlipidemia, and outpouring of counter-regulatory hormones occur no matter what the origin of the acute stressful stimuli. Our bodies seem to become the victims of continuous or repetitive stress of any origin.

Being creatures of habit, we tend to smoke too much when we are awaiting the birth of our first son, or waiting outside the boss's office to get fired. One of the best features of admitting prospective fathers in the hospital delivery suite is that they can't smoke! Some people overeat when happy (weddings, bar mitzvahs) and when sad (attending a wake or "sitting shiva").

There is no doubt that well-adjusted individuals with effective coping mechanisms can deal with stressful events on a daily basis. Busy surgeons do this regularly. The nursing and medical staffs of intensive care units and cardiac care units are bombarded externally by stressful stimuli a good part of each eight-hour shift. One deals with such stress through superb preparation and expertise, through preplanning, algorithms and protocols, and, probably most importantly, through learned dampening of one's cortical response to stressful events. But is it enough?

Stress becomes a major problem and life-threatening when it is chronic and uninterrupted. But the real *bête noir* is the situation where the distressed individual feels trapped and helpless. The inability to bring about change in a recurrent life of stress, whether a fact or perception, is the beginning of

the end. The feeling of helplessness and hopelessness cannot be overcome easily by friendly or family advice.

The middle-aged architect, in an unrealistic, unsightful fashion, wanted to have immediate surgery, discharge from the hospital in a day or two, and permission to zip back to the office in less than a week. After all, he had millions of dollars of designs on the drawing board, a staff of thirty and an expensive building to support, and an upcoming committee meeting on the west coast! Most of all, he had to prove to himself again and again that he is a good person and a success. Self-image can be an insatiable taskmaster, but a fragile self-image, coupled with a type A personality, can be lethal.

The diseases caused by, related to, aggravated by, or associated with stress are legion. All physicians can list two pages of them. Premature aging probably should be at the top of the list.

What should that architect—and any physician or surgeon in a similar situation—do? First one must recognize and understand himself. It is unquestioned that physicians are intelligent, have reasonably acceptable personalities, and are ambitious. They have a love for family, a responsibility to the community, and a charitable feeling toward the less for-

tunate. But the physician who is excessively competitive, impatient, time-oriented, and driven to attain success and possessions in order to nurture his need for acceptance and a personal feeling of well-being is susceptible to the ravages of stress.

The traditional advice to such individuals is to learn and to use relaxation techniques, to avoid excesses (tobacco, alcohol, food, work) and to get some exercise. Attitudes should be changed in relation to guilt feelings (related to pleasurable activities rather than work), to one's true worth (or self-image), and toward expensive possessions, which serve as entrapments rather than status symbols. Emotional energy should be expended, not bottled up, and ventilation may be the key.

Doctors tend to die young or at least with their boots on. Younger physicians have an opportunity to think and act differently. But their stresses are and will be different—including government intervention in medical practice, the pressures of societal influences on the health system, and the adverse economic effects of inflation/recession, and so on.

Stress, like nuclear energy, can have good or bad effects. We physicians must keep this in mind for ourselves and our patients.

A.K.

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Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.

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New Jersey has 1,792 miles of bountiful coastline—or 15 inches per citizen for their enjoyment and the enjoyment of visitors today and tomorrow. To insure a bright future for this important land area, the living sea and surrounding inland waters, we must recognize the need for their wise use and sensible development.

Fortunately, New Jersey is served by an organization dedicated to marine science education and research, helping New Jersey residents and industry to improve their awareness and understanding of the coastal environment and how they may best enjoy it.

The Consortium serves as a clearing house to initiate, coordinate and integrate marine science education and research in the state for both learning institutions and commerce. It has a membership of 23 colleges and universities with field offices in the Northern and Southern sections of the state and executive offices in Princeton.

The Consortium supports research and development through individuals and multi-disciplinary teams, educational programs in the classroom, in the field and on the sea.

It offers advisory services to assist individuals and organizations to obtain and exchange marine-related information at all levels.

In addition to the obvious need to conserve our shore areas for recreation, the Consortium recognizes the critical role these land areas play in our daily lives. For example, you may be surprised to learn that over 90% of all the commercial fish, shrimp, crabs, oysters, and countless other forms of marine life spend their early lives in the shelter of these wetland environments. New Jersey scientists have also found that wetlands are a natural barrier which keep underground supplies of fresh water from mixing with the undrinkable water of the



sea, thus providing thousands of New Jersey residents with pure well water. And, the state's barrier beaches and wetlands act as a natural buffer zone between the violence of the stormy ocean and the land where man lives and works.

The New Jersey Marine Science Consortium is a tax-exempt, non-profit marine education and research organization. You are invited to visit our facilities and take advantage of our many programs for students and the general public.

For more information write to:



Dr. Robert Ellis, Executive Director
New Jersey Marine Science Consortium
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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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East Jersey Olde Towne

Under the leadership of Joseph H. Kler, M.D., and others, a group of New Jersey citizens with a strong reverence for history, have restored a colonial village, typical of 18th century central New Jersey, in Piscataway, a virtual silver dollar's throw from Rutgers Medical School. This restoration should be of great importance to present-day New Jersey physicians because it is a link with our past, as citizens and as practitioners of the art and science of medicine.

Although the buildings, whose origins range from 1680 (Runyon Barn) to 1850 (Farley Blacksmith Shop), include the usual structures of a village of that era, the most exciting experience for me was to step into an 18th century doctor's office. Dr. Henry Vander Veer, an "eccentric gentleman," was described by a close friend as "one of the ablest physicians Somerset County had produced." Henry's uncle, Lawrence, was one of the founders of the Medical Society of New Jersey and its twelfth president in 1784.

Henry's grandfather, Jacobus Vander Veer, erected a home of Dutch and English architectural design in 1725. During the Revolutionary War, Jacobus played host to General Henry Knox, who apparently used the Vander Veer home as his temporary headquarters in 1778-1779.

The doctor's office was attached to the main house, which was occupied by the bachelor physician and his unmarried sister, Phoebe. Their strange and formal relationship, which is described carefully in the following articles* included a weekly visit by Phoebe to Henry in his half of the house and vice versa.

"DR. HENRY VANDERVEER AND SISTER

"The eccentricities of men of genius are public property, and such a person was Dr. Henry Van Derveer of Bedminster. I knew him intimately, loved and admired him, and to this day consider him one of the ablest physicians Somerset County has produced.

"He always was a most eccentric gentleman. He and his sister Phoebe lived and died at the old homestead. Neither of them ever married. The Doctor outlived his sister many years. Miss Phoebe had her own colored cook and Doctor had his. She had her own flour barrel, and the Doctor had his. She ate in her room alone; Doctor did the same. The mansion was a double house, with a ten foot entry. Her room was on one side with a stove in it; the Doctor's was on the other, with an open Franklin. The other six rooms were handsomely furnished, shut up, and seldom opened. They spent their lives in those two rooms. They had several small negroes around them.

"Phoebe once fancied she could not sleep in a bed, and accordingly reposed in a rocking chair, and was rocked all night by 'Ethiopia.' The colored is a sleepy race. She had a remedy—a stout hickory stick with a pin in the end. This

applied to 'Ethiopia' kept him awake. Alas! for human calculation. The pin was applied too sharply. The start was sudden. The chair was upset. A neck was almost broken. A severe chastisement tickled Afric's legs. Misses went to bed and always slept there after that.

"Once a week she visited brother on the other side of the entry. The heavy brocade silk, the large lace collar, and black kid gloves were put on. A formal call was made. A few hours after, Doctor, arrayed in his best English broadcloth, large ruffled shirt bosom, hair and eyebrows properly dyed, boots polished, and pants strapped down by his servant, made in return a formal call. This was all the intercourse for a week.

"April 1st was a great day—the day we always pay interest in old Somerset. Misses in silk and gloves received money. She never allowed money to touch her bare hands. There was contagion in it. The knobs of the door were of brass. A silk pocket-handkerchief was carefully placed upon the knob; then the door was opened by her. Once in two weeks she had a turkey roasted for herself, with mashed potatoes, boiled onions, and cranberry sauce. That dinner she always took at six o'clock, and ate it in bed.

"At the age of about 70 Phoebe died. There was great preparation made for the funeral, as many friends were expected. Chickens were slaughtered, and bread, pies and cakes baked. There was fine cheer in the kitchen. 'Are you not sorry that Miss Phoebe is dead?' The individual addressed was attending to a fine chicken leg. With a comical look, he replied, 'I would not care if Miss Phoebe laid dead all the time.' A month after her death there was excitement in Bedminster church. Doctor had caused a handsome monument to be erected over her remains. Some said: 'Now we will know how old the Doctor is, because he is only a little older than his sister.' Doctor, true to his instinct, because as a bachelor he would never tell his age, had neglected to put Phoebe's age on the tombstone. There were thus many disappointed people. After Phoebe's death, Doctor occupied both rooms, with the slave in one and open Franklin in the other. If too warm he went into the open fireplace; if too cold into the stove room, and this was his daily habit. For years he was the only white person in the house, his negroes being in the kitchen. As we all know, he lived to a great age, dying at about 95. You might say he never had any disease; he wore out. He studied his system carefully and acted upon strict rules. He ate animal food, but chopped it up very fine with his knife like mince meat. He always had Indian upon his table, either as cake or cornbread. I never remember seeing hot wheat bread used by him. To regulate his system, he had baked apples and ate largely of the best of oranges and pears.

*McDowell, AW in *Our Home*, Vol. I, (1873), pp. 159-160 and 211-213.

He was eccentric in love matters. He was also very eccentric about timber. He had 400 acres of the finest land in Bedminster. He saw them cut down the first tree for his new mill, gave a loud groan, and would never go to the woods after that.

"I could write a long article on his GENIUS. He was ahead of his age, and one of the ablest physicians of Somerset. We all know about his singular will, and the excitement in our County and State Courts. As a gentleman, a scholar, a physician, I much esteemed him, and many have cause to be grateful for his superior professional skill.

"OUR OLD PHYSICIANS—VAN DERVEER AND SUYDAM

"In 1840, filled with youthful enthusiasm, I came to settle in Bedminster, Somerset County. I had then just graduated from the Medical Department of the University of Pennsylvania. From that date until 1863, I was intimate, and associated much with Drs. Henry Van Derveer and Cornelius C. Suydam. Dr. Van Derveer lived near Pluckamin, and practiced in that vicinity; Dr. Suydam near the Lesser Cross Roads. Their respective patients loved and admired both, carefully studied their characters, each physician. I, as the successor of and esteemed them as men. My intercourse with them, socially and professionally, was of the most intimate nature. To embalm their characters, as men and physicians, in some feeble way, and to present them to the public as they appeared to me, form a sacred duty and labor of love.

"When I first met Dr. Van Derveer, he was upward of sixty years of age. Tall, lean looking and remarkably neat in his personal appearance, he had also the courteous manners of a gentleman of the old school; he kept good horses and was a handsome rider. Said an eccentric medical friend to a young physician, who was riding in a sulky: 'Do you wish to live as long and be as healthy as I am?' 'Yes, I would like to find out the panacea.' 'Then, young man, get out of that sulky and ride on horseback.' Dr. Van Derveer lived to a great age, was a remarkably healthy person, and rode much on horseback.

"He had some of the finest old colored servants I ever knew. I must pay a tribute of respect to those noble old blacks of Somerset County. They served us faithfully and took good care of our bodily wants. Doctor's old cook was one of these nice people: always neat, clean, happy, ready to meet you with the pleasantest face and the merriest of laughs. When she died, Doctor wept many tears, as if he had lost the best of friends. A little while after, calling to see him, he apologized to me. He thought his table did not look as neat as usual. 'I do miss my old cook so much. That young girl is good, but she does not know my habits.' Old Harry, his farmer, was a splendid fellow, a most faithful servant. His smiling face and graceful bow, particularly when a quarter touched his hand on Christmas morning, I shall never forget. The attention of these servants did much to make Doctor the able physician he was. He had no trouble about his farm and domestic affairs. Thus he could devote his time and energies to his noble profession. Old Harry was a kind of king among that sable race. He ruled with a lordly sway. Woe to the young urchin that disputed his authority! His hand was large, and there was much muscle in his uplifted and descending arm. Alas for the young scamp that felt its weight! Farm work was never neglected as long as Harry lived. Doctor, possessed of an ample fortune, and a fine library of books, never had to struggle like young physicians.

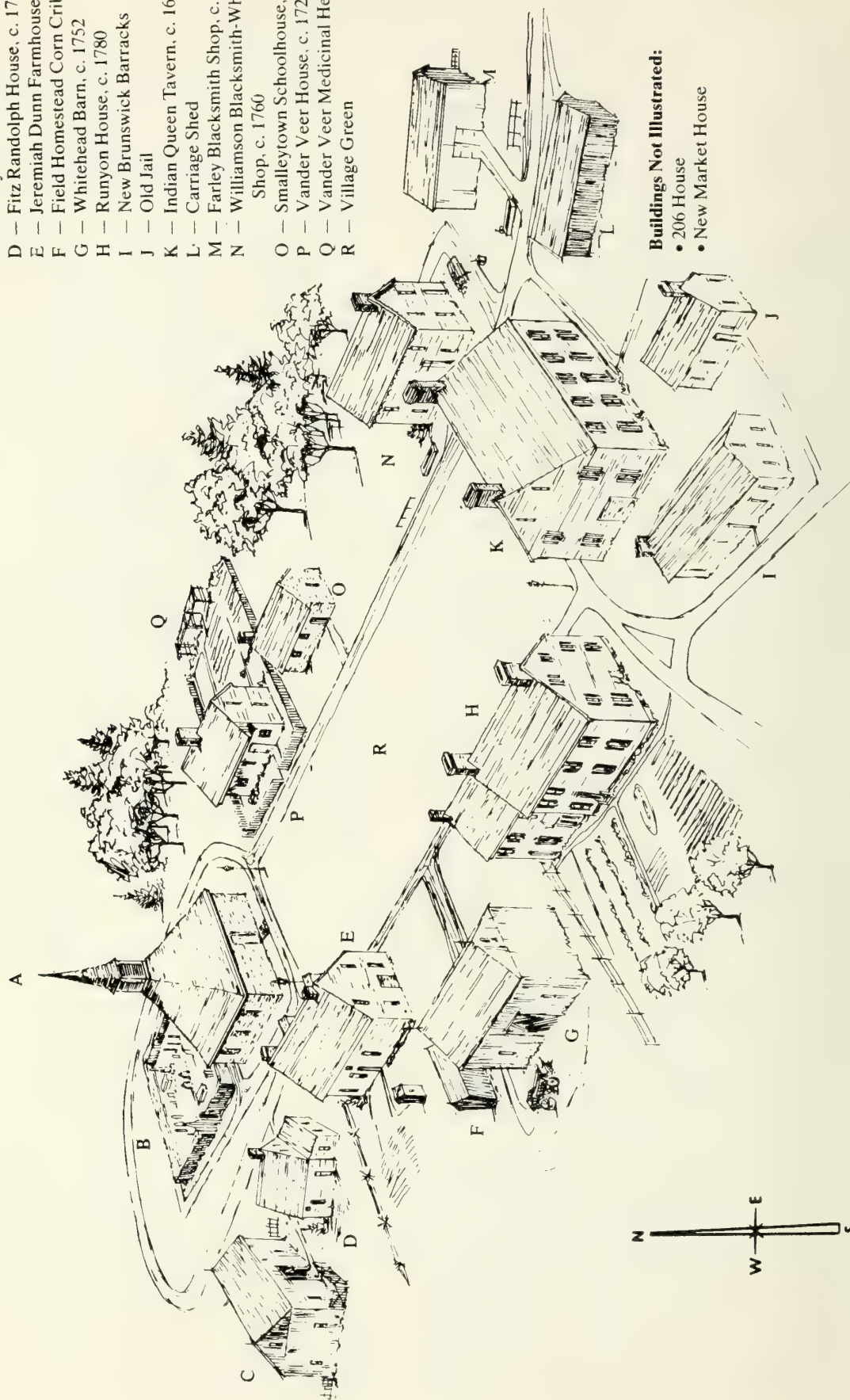
He was an inveterate reader, retained much, and applied it skillfully. His ideas were original. In conversation with me he always expressed them freely. As a rule he was a reserved, reticent man. But where the barriers were broken down and he gave his confidence, he was perfectly overflowing. Very much secluded, I was his connecting link with the outside world. He read and studied books. I, busy in my profession, studied diseases and man. Alone he could act and see where the failings were. With such a man, we must improve. With youthful daring, just like Young America, I disputed his conclusions, but time and again, in narrow straights and difficult cases, I would remember some instruction given me, which I then thought erroneous, but, acting upon them, they brought out the safest results. This practical experience gave me great confidence in the skill and foreknowledge of this remarkable man. Within the last twenty years there have been wonderful progress and discoveries in the physical sciences; in none more than in medical enemetry. Old large and ponderous doses of bark have given place to the finer chemicals. Power, strength, efficiency, are concentrated in small, pleasant doses. Doctor, in all his readings, seemed to have been anticipating this time. He always preferred those active, powerful medicines. To my narrow vision at that time it seemed like a daring innovation, but it was the true genius of the man, bursting through the clouds of doubt. He was foreshadowing what did actually happen. An older man now and knowing these things, I can admire him whose genius was thus ahead of his time. Doctor's sister was once very sick. A lady friend was nursing her. He had administered some of those powerful medicines. She seemed sinking, and alarmed the nurse. Doctor was aroused, and came into the room. 'Will she die?' was the first most natural question. 'No, no, but it was rather much, rather much.' She recovered. He used medicine that I knew nothing about in those days. I consulted him once about a lady who had cancer in the roof of her mouth. 'Doctor,' said he, 'you send to New York and get some terchloride of carbon'—a medicine then unknown. With much difficulty, and at only one store in an out-of-the-way place, I purchased the medicine. What do you suppose it was? The chloroform of the present day, thus anticipated and used by Dr. Van Derveer years and years before it was introduced into general practice. He was a fine botanist, a careful observer of plants and their medical properties. He knew just the right time to gather them, when their virtues were the greatest. We discussed these plants and roots, and on his recommendation I often used them, with marked success. I still think that as physicians we too much despise those plants which a wise, overruling Providence has placed at our disposal. I remember a child who had one of the troublesome eruptive diseases. It had baffled the skill of several physicians and finally came into my hands. I tried the usual remedy and failed. I spoke to Doctor V. about the patient. 'Go,' he said, 'and gather some clover blossoms; have them nicely cured; make a bath of them. Put the child in this bath every day; let him drink clover tea.' I did so. The old skin came off, and a new, clear skin took its place. The person is now living and is a fine-looking gentleman. Dr. was fond of the use of sanguinaria (blood root) in croup, the pleurisy root in colds, and polk-root, roasted in ashes and mashed, as a discutient in various tumours. He was convinced he could cure hydrophobia. Patients came to him from all quarters with that terrible disease, and I never knew any to die. They considered themselves cured by his remedies. I conversed with him on these points. He told me his remedy was equally effective in persons and animals. He

Buildings Illustrated

- A — Three-Mile Run Church, c. 1703
- B — Village Church Yard
- C — Runyon Barn, c. 1680
- D — Fitz Randolph House, c. 1743
- E — Jeremiah Dunn Farmhouse, c. 1745
- F — Field Homestead Corn Crib
- G — Whitehead Barn, c. 1752
- H — Runyon House, c. 1780
- I — New Brunswick Barracks
- J — Old Jail
- K — Indian Queen Tavern, c. 1686
- L — Carriage Shed
- M — Farley Blacksmith Shop, c. 1850
- N — Williamson Blacksmith-Wheelwright Shop, c. 1760
- O — Smalleytown Schoolhouse, c. 1799
- P — Vander Veer House, c. 1725
- Q — Vander Veer Medicinal Herb Garden
- R — Village Green

Buildings Not Illustrated:

- 206 House
- New Market House

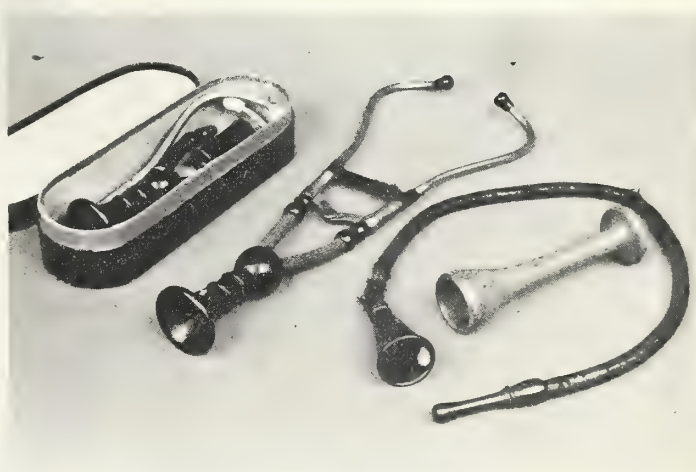




Dr. Vander Veer's Office



Colonial Period Maternity Instruments



Colonial Period Stethoscopes

once purchased some materials which failed him, but when properly cured and gathered at the right season, 'the cure was certain.' As the Doctor never deceived me, I am forced to take his testimony on this point, and he was positive in his declaration.

"At times there was a good deal of drollery, almost wagery about him. In those days fees were very low. For pulling a tooth the price was twenty-five cents. A certain wag lived not far from the Doctor, by name of 'Billy Britten.' He was a blacksmith by trade and attended to all the 'wolf's teeth' among the colts. Doctor pulled a tooth for this man, and charged fifty cents. Bill took a wolf's tooth out for the Doctor and charged fifty cents also in the blacksmith's bill. Doctor commented: 'Well, I see Billy has not forgotten the tooth I pulled out for him. We will quit even.'

"My friend very, very seldom went to church. The tale is a sad, but instructive one. Doctor was one of the committee to build the reformed Church of Bedminster. He honestly thought there was some error in the money account of the other member of the committee. When he rose to explain, the minister, ex officio moderator, told him to take his seat. The Doctor persisted. The command was now peremptory: 'Take your seat.' The Doctor walked out, and was an enemy of the Church to the day of his death. He owned all the ground around the building, but persistently refused to sell any for a burial ground. The clergyman called a few days after and apologized. Doctor remarked: 'I like to see a man a gentleman from the stump up.' He always paid a small annuity in order to keep a burial place for himself. In my religious conversation with him, he acknowledged the Divinity of the Savior, but seemed to believe in universal salvation. This want of a true religious belief was a sad blot on otherwise a noble character. While we must all acknowledge his worth

and distinguished skill as a physician, yet it is sorrowful to think that so fine a person could not have been truly a Christian man. How much, with his talents and fortune, he could have accomplished! We are all ready to pay homage to his talents; how precious we would have embalmed his memory, if he had been a pious exemplary physician."

In addition to the original Vander Veer Office, East Jersey Olde Towne has the Vander Veer Medicinal Herb Garden, maintained as Henry did to obtain drugs for his pharmacy. There also will be an herb drying "shed."

This magnificent restoration, with the actual Colonial structures, which were scheduled for demolition, is located on twelve acres of Johnson Park on the banks of the Raritan River. The location has a historical past, for it "was the scene of several bloody skirmishes between patriots and British troops" and it was there that Washington "commemorated the second anniversary of the signing of the Declaration of Independence."

To be complete, the Vander Veer House needs authentic furnishings and medical equipment from Colonial days to about 1835. Any physicians or their families who have such items and wish to donate them to East Jersey Olde Towne for placement in the Vander Veer House are urged to contact *The Journal*. If none are in your possession, dollar contributions** will help in the ultimate purchase of such items.

Come to East Jersey Olde Towne and walk through a period of American history including a visit to a New Jersey physician's office. It may help to put the fading twentieth century into perspective.

A.K.

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The Expanded Role of the School Physician *

WILLIAM J. FARLEY, M.D., Brielle

The school physician can make a much needed contribution and provide professional skill in support of the educational process if school health services avoid traditional wasteful tasks. The physician's duties are redefined with special emphasis on health education and the evaluation of the learning-disabled child.

The initiative for school health services began in the early part of the century in an attempt to control communicable disease. Further impetus was given toward the concept of the early detection of physical defects in school by the large numbers of young men rejected for military service in both World Wars. The school population still represents a captive group for which all sorts of screening programs appear to be an attractive method of case finding, frequently at the expense of the learning process. One deserves to reexamine and update school health services as well as the duties of the physician in school today.

It is the author's belief that:

- (1) the average school physician makes little or no contribution to the school, and
- (2) the family physician or pediatrician is capable by training and experience to make a substantial contribution as school physician.

HEALTH SERVICES IN SCHOOL

Health Maintenance of School Children—The primary responsibility for the health needs of children rests with their parents, not only to assure the attention needed during acute illness, but the preventive maintenance of good health through regular assessment by the child's physician. This includes a discussion of physical maturation and behavioral development with child and parent. Unfortunately, the comprehensive delivery of health care is fragmented, duplicated,

and frequently jeopardized when the school attempts to assume this role. Parents tend to abdicate their responsibility in favor of inadequate school physical examinations.

Physical Examinations in School—Yankauer's studies have shown that physical examinations in school have minimal yield as a case-finding procedure.¹ The cursory and incomplete mass examination of large numbers of healthy children is a disservice which rarely detects defects not previously known by parents, the physician, or school personnel. Many conscientious physicians have rejected school jobs because of the demands of school boards in this regard. I critically have reviewed this aspect of health services negatively because the school physician cannot afford such time-consuming examinations; it prevents him from assuming the proper duties we shall discuss subsequently.

The "sports physical" requires special consideration because of the potential hazards of athletes. The school physician, as team physician, must utilize a health status report and recommendations of the candidate's physician as the basis for fitness to engage in strenuous physical activity and contact sports. He has a responsibility to review each application and screen each candidate. It is medically un-

*Presented before the joint session of the Sections on Pediatrics and Family Practice, the Medical Society of New Jersey, 213th Annual Meeting, May 13, 1979. Doctor Farley is Director of Pediatrics, Point Pleasant Hospital, Point Pleasant, New Jersey. Correspondence and requests for reprints may be addressed to him at 834 William Drive, Brielle, New Jersey 08730.

“The cursory and incomplete mass examination of large numbers of healthy children is a disservice which rarely detects defects not previously known by parents, the physician, or school personnel.”

“During the fourth high school year each student’s health record should be inspected for any unresolved defects or problems. Students should be urged to obtain further medical advice, if needed.”

sound and it may be legally risky for a team physician to fail to obtain permission of the candidate’s physician and the parents, and to assume this responsibility for youngsters totally unfamiliar to him. My own early experience in performing thousands of “locker room physicals” on high school athletes is the same as such examinations on the general school population: the detection of unrecognized defects is negligible. The team physician, however, is the final authority of a candidate’s fitness to play. In the event of questionable fitness or special problems, a final decision should be made after discussion and conference with the candidate’s physician, parents, and the school administration.

Recommendations for Periodic Health Appraisal—The chief repository for a child’s health experience and oftentimes confidential health information is with the parents and in the office of the private physician or health facility. This information is not in school. The ongoing record of a student’s health status which is maintained in school consists of those past and present conditions relating to and affecting academic performance and activities in school. This information is obtained through a simple report form completed by the child’s parent and physician that includes any significant health problems that might influence the optimal ability to learn and fully engage in school functions, as well as recommendations, if any. The school physician, with the assistance of the school nurse, reviews each form.

This periodic health appraisal is submitted as follows during the student’s primary and secondary school career:²

(1) *Prior to entrance into school.* This represents the most important assessment in terms of future education. It properly includes birth history, developmental milestones, behavioral characteristics, evaluation of speech, hearing, and vision, and, of course, immunizations administered.

(2) *During mid-elementary school (Grade 5 or 6).* It also includes permission for competitive sports.

(3) *Prior to entrance into high school.* It will serve as an application to participate in freshman athletics.

(4) *Annual sports application.* This report form will be submitted by those participating in the school sports program prior to the initial practice, and will suffice for each team activity throughout the school year. It will include the approval of the candidate’s personal physician and signed permission of the parent to permit emergency treatment by the team physician.

(5) *Senior health review (optional).* During the fourth high school year each student’s health record should be inspected for any unresolved defects or problems. Students should be urged to obtain further medical advice, if needed. This final health review may be in the form of a group discussion or “rap session” of six to ten students. Except for a more private consultation deemed essential for any one student, the group session enables the physician, nurse, or health

educator to discuss a wide variety of biosocial as well as physical issues confronting the young adult. Certain “problem students” may be tagged for these discussions, which are stimulating and rewarding experiences for the physician and students.

School Districts Populated by Underprivileged Families—Health services provided in school must be tailored to meet the needs of the community and the children it serves. With the aid of school and local social services and agencies, every attempt must be made to seek a continuing medical facility where services may be obtained 24 hours a day for each child, especially in congested urban districts. Private care with assistance of medicaid or other third party providers may be available. Enrollment in neighborhood health centers or ongoing hospital clinics may be sought. I am not opposed to examinations in school. If done, the child or adolescent deserves no less than a private, thorough examination with the parent’s permission, presence, and assistance, if at all possible. This will provide the examiner with adequate background information. The innovative establishment of a primary care clinic facility within some schools, staffed by a physician and a school nurse practitioner, with backup in a nearby medical center, may be a feasible alternative.

DUTIES OF THE SCHOOL PHYSICIAN

The school physician traditionally has acted as a resource person to the board and administration, and as a link between the school, the medical community, and public health authorities. He has protected the health and safety of students and faculty by the surveillance of school employees and personnel, buildings, and grounds. In addition, a sound physical education curriculum should be fostered to provide adaptive programs for the handicapped. A program of intramural and extracurricular sports for all students is encouraged; this might stress fitness and enjoyment in later life such as hiking, skiing, tennis, golf or even jogging, rather than continued emphasis on more structured group athletics.

There are three areas of concern to the school physician which deserve special attention, namely—competitive athletics, participation in the Child Study Team evaluation, and health education.

COMPETITIVE ATHLETICS

The “sports craze” in this country has become a way of life and a multi-billion dollar business to which the aspiring young athlete is not immune. A simulated professional atmosphere and postseason games have become commonplace even for the prepubescent child in elementary school. One must question the educational and psychological value of such experiences. Greater interest and expertise in sports medicine enables the physician to protect the vulnerable youngster, especially during rapid growth periods and to permit better evaluation of fitness, body habitus, stature,

“There are three areas of concern to the school physician which deserve special attention, namely—competitive athletics, participation in the Child Study Team evaluation, and health education.”

weight, and muscle distribution and adaptation for athletics. Lectures and practical demonstrations to team candidates, coaching staff, and trainers during practice periods, early in the season can be a valuable educational program. Instruction may be given in anatomy and physiology in relation to conditioning, the mechanics and prevention of injury, early treatment and subsequent habilitation, including physical therapy, diet and nutritional requirements, emergency procedures and policy, and the application and misuse of protective equipment. These teaching sessions may be oriented toward each sport, for example—the hazards and disadvantages of weight reduction in wrestling, the risk of heat exhaustion and salt depletion during early fall football practice, and up-to-date advice for the female athlete.

The team physician whose only contact with the sports program is the required presence for two hours at the Saturday home football game is not a “team doctor.”³

CHILD STUDY TEAM PARTICIPATION

Federal and state laws mandate that every school child with a learning disability shall be identified, classified, and provided with a special educational program. This evaluation by the child study team shall include a comprehensive health appraisal by the school physician or a review by the school physician of an appraisal submitted by the child's physician. The school physician, therefore, is an essential component of this multi-disciplinary team.⁴⁻⁶ Unfortunately, in most school districts, there is limited, if any, medical input into the evaluation process. The degree of participation of the physician is commensurate with his interest and knowledge. The school physician may require a reassessment of previous training in normal and deviant child development and behavior and training to measure his knowledge of educational methods. Establishment of a satisfactory rapport with the team and its members is essential.^{7,8}

A workable approach to the comprehensive medical evaluation of the learning-disabled child is essential. It consists of three parts—a historical review, a physical and neurological assessment, and comments and recommendations. As is usual in medicine, the most important part is an adequate history furnished from a personal interview with the parents and separately with the child, and from a report of the classroom observations of the child's teachers. The neurological examination is a combination of mini-tests obtained from many sources that may demonstrate so-called “soft-signs.” The school physician must realize that the neuro-developmentalists may not agree on their relevance, however.⁹ The following outline is an attempt to “put it all together” in order to encourage greater participation in the child study team by the school physician or private practitioner.

COMPREHENSIVE MEDICAL EVALUATION

1. Historical Review

Social and Family Background—

Parents—marital relationships, disruptions, inherited conditions, physical or mental illness, educational attainment, school problems.

Siblings—ages, sex, grades, academic problems, deviant behavior.

Perinatal Experience—

Prenatal stress and illness, maternal age, weeks gestation, delivery, birth weight, neonatal complications, early infant temperament, weight gain, feeding difficulties.

Development—slower or faster—

Motor milestones, habit patterns of sleep, toilet training, language and speech.

Behavioral Characteristics

Teacher observations—skills, attention, antisocial activity.

Parent accounts—personality traits, self-image, deprivation

Peers—social interaction, recreation.

Medical History

Chronic illness, CNS infections, seizures, head injury, orthopedic conditions, eye muscle imbalance.

2. Physical and Neurological Assessment

Physical Examination—

General appearance, stature (percentile, height, weight), head circumference, stigmata, organ abnormalities, blood pressure, vision and audiometric testing, blood studies, urinalysis.

Neurological Examination—

Traditional (usually “negative”)

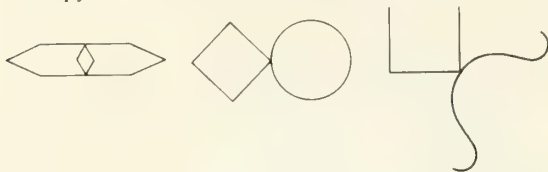
Gross motor activity, balance, coordination, reflexes, cranial nerve function, sensory intactness

Expanded—Neuromaturational^a

1. Behavior and personality—cooperation, mood, response to directions, activity level
2. Speech—fluency, phonation, articulation
r, t, sh (6); s, th, tr, st (7)—90%
3. Dressing—(4-5), shoe laces (6)
4. Gait tests
toes, heels (3), tandem (5), hopping (5), skipping (6+)
5. Modified Romberg
outstretched arms and fingers—involuntary movements, spooning, drift, jerks (Precht), stand on one foot—10 seconds (5), 20 seconds (8)
6. Fine and rapid repetitive movements
V sign, extend little and index finger (6-7)
fingers to thumb apposition (5-10)
hand—pronation, supination (7-8)
palm slap, knob rattle (7-8)
mirror movements—synkinesis (up to 7-8)
7. Dual stimulation test—tactile discrimination
eyes closed, touch both hand and cheek, rotate (6-7)
8. Auditory recall—sequencing
6 digits (9-10), 4 (4-6), 5 (6-8), 3 backwards (6-8)
serial commands—3 (4-6), 4 (6-8), 5 (8-10)
9. Dominance—controversial
hand—write, throw, clap hands
eye—pinhole, otoscope
foot—kick, step out

^anumbers in parentheses refer to age in years

10. Right-left orientation
on self (6), crossed on self (7), on examiner
(8-10+)
11. Paper and pencil tests—visual motor and spatial
integration
numbers, letters d/b, p/q—reversals (up to 6)
geometric figures
copy circle (3), cross (4), square (5), triangle (6),
diamond (7)
Bender-Gestalt forms—degree of competence
copy:



Draw-a-man (and woman) test—Goodenough
score for cognitive function (IQ)

Psychic content

12. Picture and storybook
comprehension, imagination, reading ability

3. Comments and Recommendations

Significant events in historical review.

Abnormal physical findings and organic defects.

Indications of any maturational lag or delay in neuro-
integrative function.

Opinion of principal problem area, dependent on more
definitive testing by team—avoid diagnostic labeling.

Demonstrable assets and normalcy of test findings as well.

Recommendations may include:

Hints for practical behavioral management and optimal
emotional adjustment.

Realistic expectations of the child's deficiencies and utili-
zation of strengths in teaching—avoid attempt at an "educa-
tion prescription!"

Parental guidance and counseling for better understanding
and lessening of anxiety.

Caution in ordering unnecessary diagnostic or neurological
investigations or referrals.

Psycho-therapeutic drugs with adequate monitoring and
cooperation of parents and private physician.

Attendance at child's Child Study Team conference.

HEALTH EDUCATION

One must recognize the fact that psychosocial problems
are a major concern of today's youth and do not permit a
happy and productive life for many. The school cannot be
held responsible for the cultural ills of a troubled society or
the breakdown of family life but health education that
addresses itself to these problems should be given top
priority in the school curriculum. Learning for living is the
basic educational challenge.

Doctor literally means one who teaches; teaching preven-
tive health to one's patients is a daily task. There is no aspect
of health education with which the school physician should
not be familiar. As teacher and medical advisor, the support
and prestige one can bring to a school program is impressive.
Crash programs and didactic, one-shot lectures on drug and
alcohol abuse, sex and venereal disease, teenage pregnancies,
or smoking are largely ineffective. They must be replaced by
a comprehensive, continuous, coordinated curriculum from
kindergarten through high school. Physiological and emo-
tional growth and development, human biology and sexuali-
ty, peer and family relationships, and deviant behavior and
disease states should be introduced at appropriate grade
levels.

Parental involvement in education is a necessary and
neglected aspect of the school program but it must comple-
ment and support classroom material and instruction in a
cooperative effort. The school physician can be a helpful
liaison between the school, parent, and community.

SUMMARY

The school physician cannot afford the luxury of wasting
time and professional skill in tasks of little merit for there is
too much to do. There is a genuine need for his services as a
school health specialist. Medical schools and pediatric and
family practice residency programs should provide sufficient
training. A reorientation and redefinition of the responsi-
bilities and duties for this expanded role have been presented.

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Total Parenteral Nutrition: Complications and Technical Problems

GEORGE J. PAUL, M.D., Trenton*

The complications and technical problems related to total parenteral nutrition via subclavian vein catheterization were reviewed in 100 patients. Catheter sepsis was only three percent, probably because of adherence to strict aseptic technique both in insertion and maintenance of the catheter. Total parenteral nutrition can be employed with an acceptable risk factor if close attention is paid to all details.

Although different terms are used for this therapeutic modality, the usual are total parenteral nutrition, intravenous hyperalimentation, or just simply hyperalimentation. We shall use the term total parenteral nutrition (TPN).

TPN has gained wide acceptance and is a valuable addition to the physician's armamentarium. It supplies the patient with a nutrient solution consisting of amino acids, carbohydrates, electrolytes, vitamins, trace elements, and other micronutrients necessary to conduct normal metabolic processes. The procedure consists of infusing highly concentrated nutrient solutions continuously through an indwelling catheter which is inserted into a subclavian vein and directed centrally into the superior vena cava. (See Figure 1)

The aim of TPN is to supply essential substrates to attain a build-up of lean body tissue, maintain positive nitrogen balance, and to achieve an anabolic state. The obvious importance of this cannot be overemphasized.¹

As with other invasive procedures, there are complications and technical problems associated with TPN. Most complications are avoidable, and low rates of morbidity are the rule when TPN is performed properly.

All solutions must be absolutely free of microbial or particulate matter. They must be devised precisely and compounded to provide the correct requirements of amino acids, dextrose, intracellular and extracellular electrolytes, and vitamins to the recipients. Although TPN is relatively

safe and very effective, it does require close monitoring by an experienced team which must expend considerable time and effort.

At our institution, the TPN Unit has operated since November 1976, at which time a formalized protocol describing the medical, nursing, and pharmacy aspects of TPN was adopted. This report describes our experiences concerning complications and technical problems among our last 100 consecutive TPN patients.

BASIC TPN PROTOCOL

Although TPN must be individualized for each patient, we have found that a basic TPN protocol used as a general guide is useful. While there may be many variations, the basic steps and elements in TPN are presented in Table 1. From this table, the potential problem areas easily can be discerned.

COMPLICATIONS AND TECHNICAL PROBLEMS

Although TPN is a relatively safe procedure if used with care and discretion, the practitioner should be vigilant with all patients receiving TPN. Table 2 shows a comprehensive listing of potential complications.²⁻⁴

We like to use the term "complication" as indicating an

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Figure 1—Catheter in usual position: entering the subclavian vein and passing into the superior vena cava.

untoward reaction by the patient to TPN; and we use "technical problem" when referring to equipment or procedural difficulties. In some instances, a technical problem may cause a complication so both will apply concomitantly to the same patient. Table 3 lists the complications and Table 4 the technical problems we experienced in 100 consecutive cases of central venous catheterization and the administration of total parenteral nutrition.

PNEUMOTHORAX

Four patients exhibited x-ray evidence of pneumothorax following the insertion of a subclavian vein catheter. In three cases, the pneumothorax was less than 10 percent; a fourth patient not only had bilateral involvement, but the degree was 25 percent. Pneumothorax is more likely to happen to a very thin patient; when multiple punctures are necessary; and when the operator inadvertently angles the needle away from the usual cephalad and coronal course. If the pneumothorax is less than 20 percent and the patient manifests no clinical difficulties, no action need be taken. In cases of greater than 25 percent pneumothorax, we believe a chest tube and underwater seal should be utilized. This usually can be discontinued within a 48 to 72 hour period. Naturally, serial chest x-rays should be made to provide continuous evaluation.⁴ (See Figure 2)

Table 1
Basic TPN Protocol

1. Appropriate patient selection
2. Consultation among TPN team members
3. Basic evaluation of nutritional and other requirements
 - (a) Fluids and electrolytes
 - (b) Blood chemistries
 - (c) Caloric and nitrogen requirement estimates
 - (d) Other areas of care needed by the patient
4. Selection and preparation of solutions
5. Catheter insertion⁸⁻¹³
6. Catheter maintenance
7. Solution flow adjustment and monitoring
8. Daily patient evaluation
 - (a) Weight
 - (b) Clinical status
 - (c) Laboratory data
9. Complication recognition and management
10. Termination of therapy
 - (a) Therapeutic goal reached
 - (b) Sepsis or other complication occurs

Table 2
Potential TPN Complications

1. Pleural Space
 - (a) Pneumothorax
 - (b) Tension pneumothorax
 - (c) Hemothorax
 - (d) Hydrothorax (intrapleural infusion)
2. Mediastinum
 - (a) Hemomediastinum
 - (b) Hydromediastinum
 - (c) Superior vena cava syndrome
3. Neck
 - (a) Subcutaneous emphysema
 - (b) Arterial injury (hematoma, A-V malformation, etc.)
 1. Subclavian artery
 2. Carotid artery
 3. Cervical and thoracic arteries
 - (c) Nerve injury
 1. Phrenic nerve
 2. Vagus nerve
 3. Recurrent laryngeal nerve
 4. Brachial plexus
 - (d) Thoracic duct injury
 1. Thrombosis
 2. Chylothorax
 3. Lymphatic fistula
 - (e) Tracheal injury
4. Veins
 - (a) Laceration with hemorrhage
 - (b) Air embolism
 - (c) Catheter embolism (paradoxical embolism)
 - (d) Venobronchial fistula
 - (e) Superior vena cava thrombosis
5. Cardiac
 - (a) Arrhythmias
 - (b) Myocardial perforation (by the catheter)
 1. Hydropericardium
 2. Tamponade
 - (c) Coronary sinus block
6. Catheter sepsis
7. Metabolic complications
 - (a) Glucose intolerance
 - (b) Hyperosmolar hyperglycemic nonketotic dehydration and eventual coma
 - (c) Electrolyte imbalance
 - (d) Vitamin and mineral excesses and deficiencies
 - (e) Reactions to amino acids
 - (f) Fluid imbalances

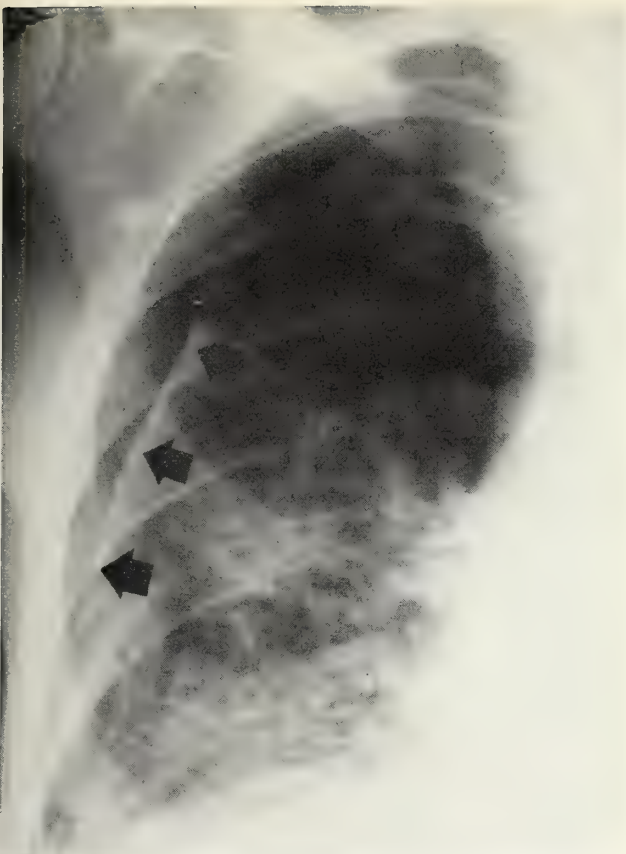


Figure 2—Partial pneumothorax following insertion of subclavian catheter.

CATHETER SEPSIS

Our three percent sepsis rate is in line with that seen in experienced groups. Any sudden, unexplained fever in a patient who has a central venous catheter must be considered a manifestation of catheter sepsis unless proved otherwise. Common sites of infection for the cause of fever, such as urinary and respiratory tracts, wound infections, and so on always must be considered. If no cause of the fever can be found, the central catheter is removed and the tip of the catheter, as well as its fluid content, is cultured. A new catheter is inserted into the contralateral subclavian vein.

If sepsis was due to the catheter, the patient's temperature usually will return to normal within 24 hours of removal of the catheter. Positive cultures are also confirmatory of the diagnosis. It must be remembered that many patients receiving TPN are already bacteriemic and septicemic from their primary illness; a positive culture from the catheter tip in these cases doesn't necessarily mean catheter sepsis.

All of our three patients became afebrile following removal of the catheters. Although a positive culture was obtained in only one patient, the prompt response to catheter removal clinically confirmed the diagnosis of catheter sepsis.^{2,5,6}

HYPERGLYCEMIC, HYPEROSMOLAR, NONKETOTIC DEHYDRATION

This complication, manifested in two of our patients, is a potentially deadly one, more so because its onset is usually slow and insidious.^{3,7}

Its etiology is related directly to the large amount of

Table 3
Complications in 100 patients

	No. of Patients
Pneumothorax	4
Catheter sepsis	3
Hyperglycemic, hyperosmolar, nonketotic dehydration ...	2
Mediastinal hematoma	1
Hydrothorax ^{3,14,15}	1
Hemopneumothorax	1
Perforation and then reentry of catheter into subclavian vein	1

Table 4
Common technical problems

	No. of Patients
Catheter into the internal jugular vein	8
Discontinuity in the IV administering apparatus	7
Improper flow rates	7
Line filter clogging	5
Catheter clotting	4
Catheter displaced out of the vein	4

dextrose used. The average TPN patient receives upwards of 750 grams of dextrose per 24 hours. The patient's urine must be monitored carefully for glycosuria every six hours, and blood sugar levels are determined daily. We try to keep the glycosuria below 2+; and blood sugar levels below 200 mg/dl.

The hyperglycemia may be caused by several factors: too rapid an increase in the amount of dextrose given daily to a new TPN patient (full dextrose dosage usually requires five days to be achieved); too rapid a flow rate of the TPN solution; patient is either a latent or overt diabetic and has insufficient endogenous insulin production; and failure to give adequate exogenous amounts of insulin.

The patients often present with blood sugars as high as 1000 mg/dl. They have 4+ glycosuria, but no ketonuria. Serum osmolarity will be in the 350-400 mOsm range (versus a normal of 280-300 mOsm). The patient will appear obviously dehydrated.

Treatment consists of the administration of sufficient insulin and large amounts of fluids administered rapidly. In a patient weighing 60 kg, a 25 percent loss of body water means at least a 7.5 liter deficit caused by osmotic diuresis. More than half of this volume should be replaced within the first 12 hours of treatment. The point to remember is that fluid volume is depleted and must be replaced.

OTHER COMPLICATIONS

As seen from Table 3, there were four other complications in our series. All were self-limited and none proved to be serious. Of interest is a patient in whom the catheter perforated the subclavian vein, made a loop in the surrounding soft tissue, and then somehow reentered the vein and continued down into the lumen of the superior vena cava. This was discovered when the usual post-insertion chest x-ray was read (see Figure 3). Figure 5 shows hydrothorax and Figure 6-b demonstrates mediastinal hematoma.

TECHNICAL PROBLEMS

In our series, we have encountered a small number of technical problems, only one of which was a threat to the

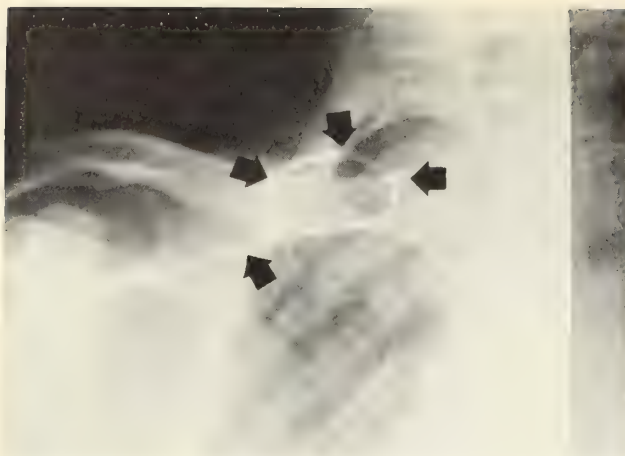


Figure 3—Catheter making a loop after perforating the subclavian vein and then reentering the vein.

patient. We have had eight patients in whom the catheter, after being inserted into the subclavian vein, went superiorly into the internal jugular vein rather than inferiorly into the superior vena cava. This diagnosis of misdirected catheter is made on the post-insertion chest x-ray. Our practice is to take these patients to our radiology department where, under fluoroscopy and image intensification, the catheter is manipulated and redirected into the superior vena cava. (See Figure 4)

Some of the other listed problems are much more mundane and relatively easily solved. Discontinuity in the intravenous administering apparatus is corrected by securing all connections between burettes, tubing, catheters, and so on with adhesive tape to prevent them from coming apart. Improper flow rates require educating the floor nurses as to the importance of constant vigilance with these patients. The rate is checked and recorded every hour. We have discontinued the use of mechanical fluid pumps because of their great expense, mechanical failures, and difficult maintenance. Burratrol® apparatus, refilled hourly with the prescribed volume of fluid, is used.

When our TPN Unit first was started in November 1976, in-line filters were used. We found they clogged easily and therefore proper flow rate was difficult to maintain. It also meant having to change the intravenous tubing several times a day, thereby exposing the patient to potential contamination and infection. For the past 18 months, we have discontinued the use of any in-line filters and have not had any evidence of any untoward reactions.

Catheter clotting usually is caused by some inadvertent kinking of the intravenous tubing or the external portion of the catheter, thereby allowing a backflow of blood into the catheter with subsequent clotting. Vigil will prevent this. Catheter displacement is prevented easily by the placement of several anchoring sutures through skin and around the proximal end of the catheter.

A potential complication which we have not experienced, but which must be considered in all patients receiving TPN is hypoglycemia due to abrupt cessation of TPN therapy. Patients receiving full TPN therapy produce large quantities of endogenous insulin due to the large dextrose loads (750 g daily). If the flow of solution suddenly is interrupted (kink in tubing, displacement of catheter, breaking of a solution bottle, and so on), the patient may become markedly hypoglycemic. All personnel should be instructed to infuse 10 percent D/W immediately into these patients until the



Figure 4—Catheter in the internal jugular vein.

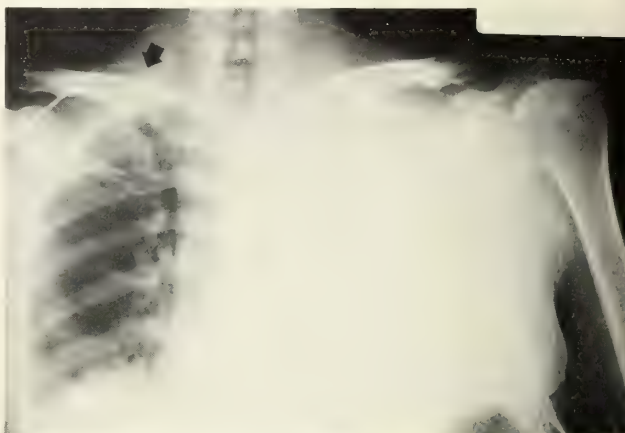


Figure 5—Left hydrothorax due to misplaced catheter.

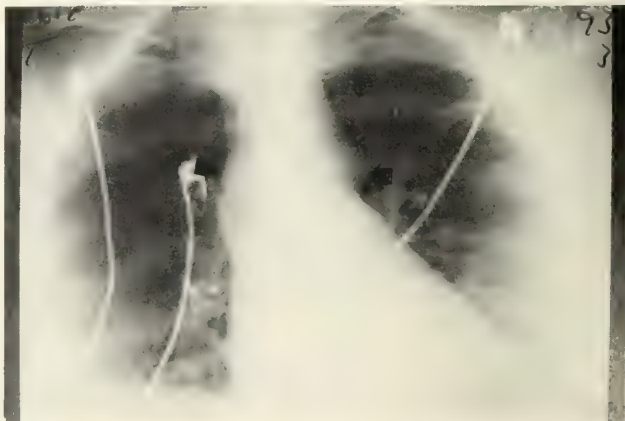


Figure 6-A—Arrows show width of mediastinum prior to catheter insertion.

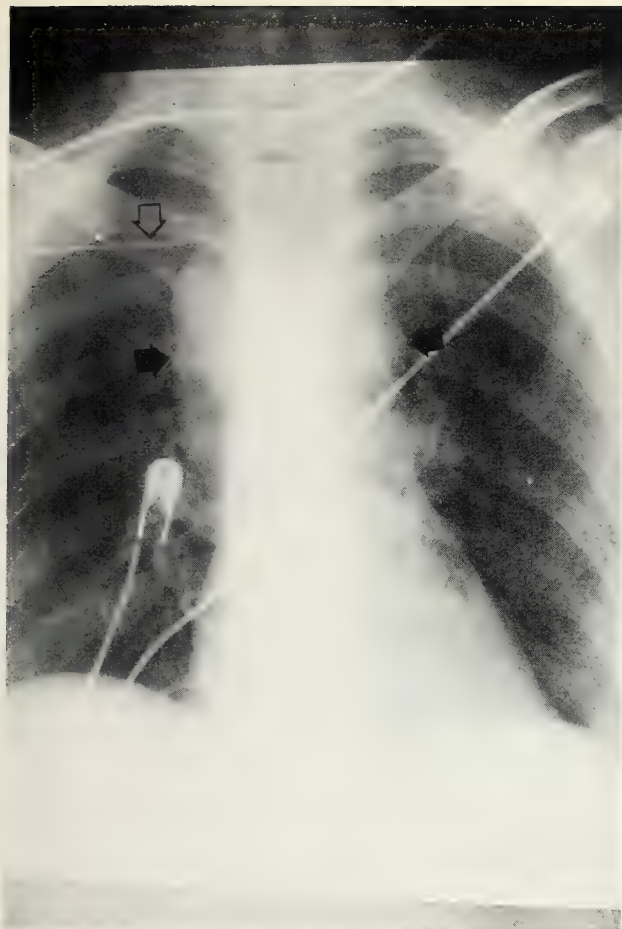


Figure 6-B—Black arrows show widening of mediastinum due to hematoma following insertion of subclavian catheter (white arrow).

usual TPN solution and flow rate is resumed. At the conclusion of therapy, the dextrose load should be reduced gradually over a period of several days as a precautionary measure to prevent insulin shock.

SUMMARY

Total Parenteral Nutrition (TPN) is a modality which enables the physician to supply all essential nutrients to the patient. It involves the infusion of concentrated nutrient solutions via an in-dwelling catheter placed in a major central vein.

As with any other procedure of major consequence,

certain complications and technical problems may occur. Although most of these are of minor import, several of them can be serious and even life-threatening. The major areas of concern involve catheter placement and maintenance, catheter-related sepsis, monitoring of the fluid, electrolyte and nutrient status of the patient, and the recognition of and proper correction of complications and technical problems.

Our review of 100 TPN cases shows that with proper diligence and care, a low-risk level can be maintained, and is clearly outweighed by the benefits derived from nutritional support of the patient.

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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.



Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
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When is a chest pain a heart attack?

Often, determining the cause of a chest pain is difficult. So how can a doctor tell when it's a heart attack?

The American Heart Association is supporting research to help doctors identify heart attacks as early as possible so the victims can receive fast, effective aid.

One research method is myocardial scintigram. It allows accurate diagnosis of heart damage without catheters, without the injection of dyes.

With it, doctors can actually look inside a patient's body to evaluate the heart's condition. They can see a cross-section of the heart and its chambers and can determine the heart's effectiveness as a pump. If there is heart damage, the doctors can see exactly where—and how extensive—it is.

Myocardial scintigram is one of the techniques pioneered through research supported by the American Heart Association.

Please give generously to the American Heart Association 

WE'RE FIGHTING FOR YOUR LIFE

Myocardial Abscess: Clinical and Pathologic Findings in Twenty Patients*

M. ASLAM, M.D., M.Y. SANDHU, M.D.,
P. SCHWEITZER, M.D., M. HERSHKOWITZ, M.D., Jersey City

Twenty of 10,651 autopsied patients at the Jersey City Medical Center showed myocardial abscess (0.187 percent). *Staphylococcus aureus* was the most common organism. Previous myocardial infarction did not increase susceptibility. No abscess was diagnosed in a living patient. There were no cures. The future may be more favorable for such patients.

A review of 10,651 autopsies performed at the Jersey City Medical Center from April, 1931 to June, 1976 yielded 20 cases of myocardial abscess, an incidence of 0.187 percent. The unique case of primary pneumococcal myocardial abscess which stimulated the present study is described below. We have reviewed and commented on the significant previous autopsy reports of myocardial abscess since 1931.

CASE REPORT

A 55-year-old male came to the Jersey City Medical Center on November 14, 1975, with constant, severe retrosternal chest pain, radiating to the back, for one day. The pain was unrelated to exertion, ingestion of food, or postural changes, and was the first such episode. The patient was an alcoholic, previously treated for a gastric ulcer, confirmed by x-ray examination without endoscopy. A chest x-ray in October, 1975, was normal, with no cardiac enlargement (Figure 1).

There never had been features of alcoholic cardiomyopathy, such as arrhythmias, congestive heart failure, pulmonary emboli, or cardiomegaly. Physical examination on admission showed an alert, well-developed, well-oriented, cooperative patient. The pulse rate was 120/min., the blood pressure 80/60 mm Hg in both arms, the rectal temperature 36°C, and the respiratory rate 40/minute. The skin was normal. The jugular venous pressure was elevated and the CVP was 18 cm of water. The point of maximum

intensity of the heart could not be localized. The heart sounds were distant. S₁ was normal, S₂ was normally split, A₂ and P₂ were normal, and there were no murmurs, rubs, or clicks. The lungs were clear. The liver edge was 3 to 4 cm below the right costal margin, smooth and non-tender. There was no splenomegaly. The digital rectal examination was normal, with guaiac-negative brown stool. The ocular fundi showed arteriolar-venous nicking. The remainder of the physical examination was normal.

Laboratory Data: White blood cell count was 24,400/mm³ with 82 percent polymorphonuclears. The hemoglobin was 9.4 gm/dl, hematocrit 28.9 percent, chlorides 96 mEq, CO₂ 12 mEq, K 4.9 mEq, Na 132 mEq, blood urea nitrogen 17 mg/dl, and blood glucose 244 mg/dl. Blood gas analysis showed a pH of 7.4, a bicarbonate of 13.8 mEq/L, total CO₂ 14 mEq/L, oxygen saturation 86 percent, and PO₂ 53 mm Hg. X-ray examination of the chest showed cardiomegaly with a configuration suggestive of pericardial effusion. The lungs were clear (Figure 2). The electrocardiogram showed sinus tachycardia at a rate of 120/min., and a pattern of

*This study is from the Jersey City Medical Center where Dr. Hershkowitz is Director, Department of Medicine. Drs. Aslam and Sandhu were senior residents in cardiology at that institution; they now are residents in cardiology at the Bronx Veterans Hospital in New York; Dr. Schweitzer was director of cardiac laboratories at Jersey City Medical Center and now is chief of the cardiac section at the Bronx Veterans Hospital. Correspondence may be addressed to Dr. Hershkowitz at Jersey City Medical Center, Jersey City, NJ 07304.

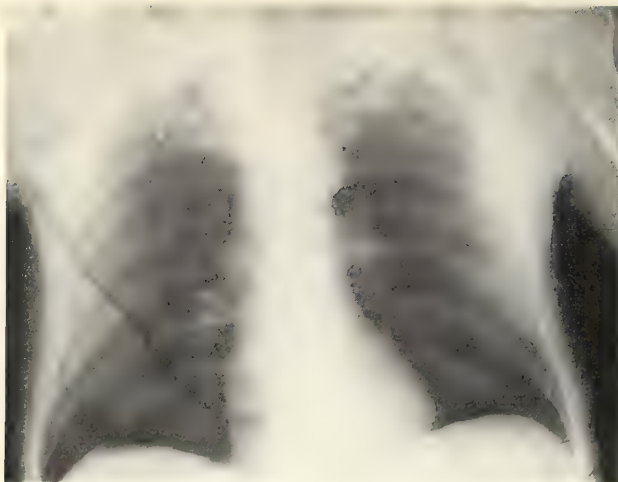


Figure 1—Chest x-ray in October, 1975, showing normal heart with no enlargement.

infero-lateral myocardial infarction, age undetermined (Figure 3).

Hospital Course: Soon after admission, a pericardiocentesis was performed via the infrasternal approach and yielded 140 ml serosanguinous fluid, which did not clot. The protein content was 6.1 gm/dl, and the white cell count was 23,870/mm³ with 98 percent polymorphonuclears. Repeat blood gas values one hour after admission while receiving 40 percent O₂ by nasal cannula showed a pH of 7.14, a bicarbonate of 6.8 mEq/L, and total CO₂ 7.3 mEq/L. The patient was given 225 mEq bicarbonate intravenously. Urine output in the first two hours was 15 ml and did not improve after administration of 80 mGm furosemide intravenously. The patient deteriorated and had a cardiac arrest four hours after admission, unresponsive to resuscitative measures.

Autopsy Report: The pericardial fluid culture grew pneumococcus Type III. Three blood cultures grew pneumococcus Type III.

The pericardial cavity contained 200 ml hemorrhagic fluid. There were massive adhesions between the pericardium and epicardial surface of the left ventricle. The heart weighed 590 gm. The left ventricular wall was two cm and the right ventricular wall one cm thick. There was myocardial liquefaction and abscess formation in the anterior wall of the left ventricle, over an area measuring four cm in its greatest diameter.

Microscopic Examination: Showed a myocardial abscess composed of degenerated polymorphonuclear leukocytes with invasion by fibroblasts. There were scattered hemosiderin-containing macrophages (Figures 4 and 5). A gram stain showed gram-positive diplococci. Purulent material from the abscess grew pneumococcus Type III.

Coronary Arteries: The right coronary artery showed atherosclerosis with 80 percent occlusion and contained a recent thrombus. There was 40 percent occlusion of the left anterior descending artery.

The Lungs: Did not show any focal lesions or infiltrates. Lung cultures were negative.

In the sigmoid colon there was an 8.5 cm x 5.0 cm necrotic fungating adenocarcinoma, composed of haphazardly distributed malignant glands, lined by high columnar epithelium with pleomorphism, large nuclei, and prominent nucleoli with numerous mitotic figures. The tumor extended to the deep muscular layer but not to the serosa. No metastases to other sites were found.



Figure 2—Chest x-ray on November 14, 1975, showing cardiomegaly with configuration suggesting pericardial effusion. Compare with figure 1.

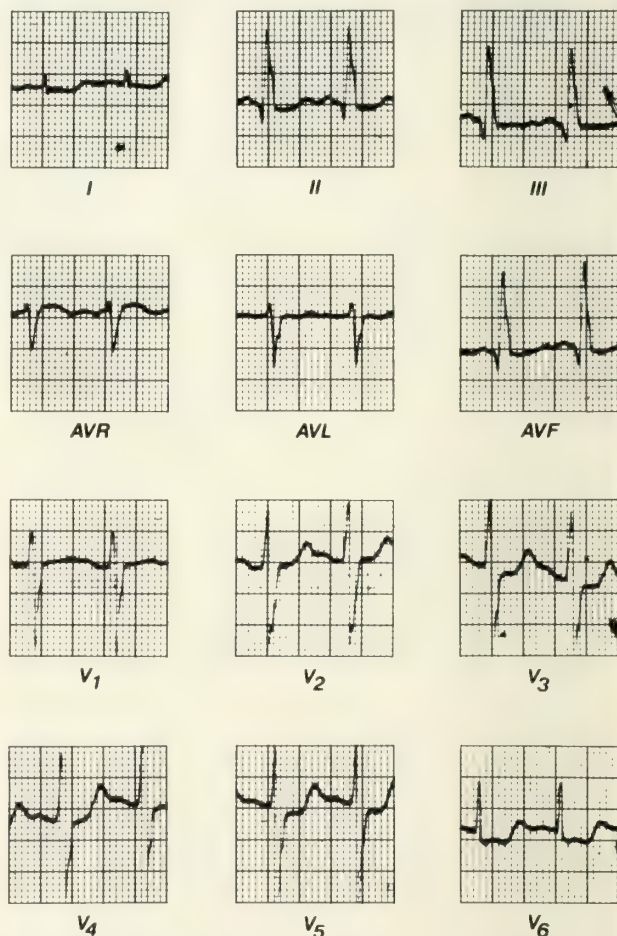


Figure 3—Electrocardiogram on November 14, 1975, showing sinus tachycardia at rate of 120/minute and pattern of inferolateral myocardial infarction of indeterminate age.

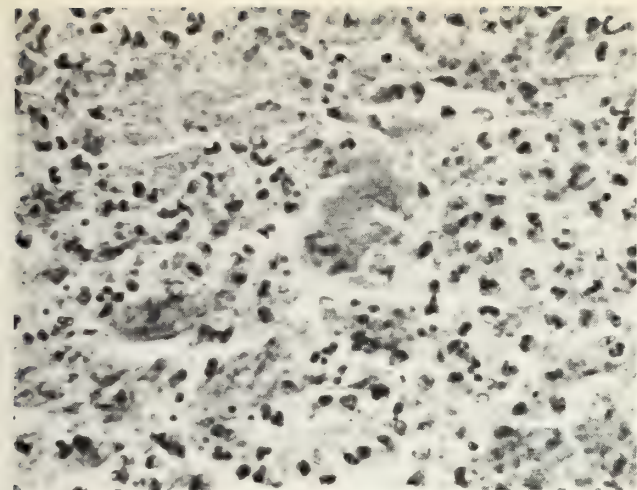


Figure 4—Histologic section of myocardium of left ventricle from area of abscess, showing liquefaction necrosis and degenerated polymorphonuclear leukocytes.

COMMENT

Primary pneumococcal pericarditis, without demonstrable source of infection in the lungs or elsewhere, is well known. Our patient's pneumococcal pericarditis was accompanied by a myocardial abscess. The clinical picture of chest pain, pericardial effusion, and shock did not lead to the exact etiologic or anatomic diagnosis while our patient was alive.

DISCUSSION

Myocardial abscess may occur in any patient with overwhelming infection. Such infections are not rare in patients who are immunosuppressed by steroids and anti-neoplastic chemotherapy, and in some cardiac surgical patients. Thus we may expect a rise in the low incidence of myocardial abscess, which has been below 0.6 percent of autopsied deaths in all reported series except that of Sanson *et al.* where it was 1.52 percent¹⁻⁴

Myocardial abscesses usually are small and multiple. They may develop in healthy or in previously infarcted myocardiums.⁵ The clinical features are deceptive, appearing as a pre-existing septicemia, plus irregular chest pain, and infrequent signs of pericardial effusion, pericardial tamponade, and cardiac rupture. The most common organism has been *Staphylococcus aureus*, but it is being displaced by others now.^{1,2}

The pertinent findings in our twenty patients with myocardial abscess are given in Tables 1, 2, and 3.

A review of 10,651 autopsies performed at the Jersey City Medical Center in the 45 years from 1931 to 1976 showed that myocardial abscess was a relatively rare entity. We could confirm only 20 cases, an incidence of 0.187 percent. Five previous studies—by Saphir in Boston, Flaxman in Chicago, Ryon *et al.* in Philadelphia, Sanson *et al.* in Chicago, and

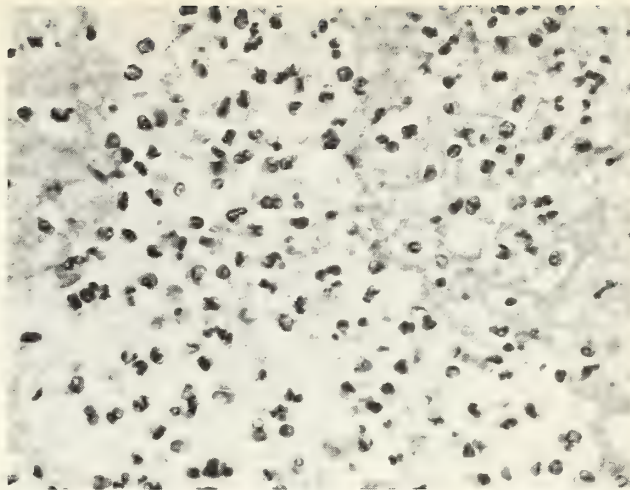


Figure 5—Higher magnification of histologic section shown in figure 4.

Kim *et al.* in Houston—showed incidences of 0.56 percent, 0.2 percent, 0.18 percent, 1.52 percent, and 0.57 percent respectively.^{1-4,6} In our study, men exceeded women by 3:2. Sixteen patients were white and four were black, roughly reflecting the population mix of Jersey City and Hudson County during the years of the study. Cases occurred from infancy to the ninth decade, with most in the 40 to 70 year group. Table 1 gives the age group distribution by decades.

Septicemia was the major precursor of myocardial abscess. Fifteen of our 20 patients were septicemic (75 percent). Five of twenty (25 percent) had endocarditis. Thirty-five years ago, all of Saphir's 32 cases of myocardial abscess were septicemic, but not one had endocarditis.¹ This certainly would be different today. Flaxman's 29 cases included eight patients with endocarditis, and in Kim's 63 cases there were eleven with endocarditis.^{2,6} Flaxman also reported seven patients with acute osteomyelitis, a rarer predisposing factor for myocardial abscess today.² Waldvogel reported a decline in osteomyelitis at autopsy from 3.3 percent in 1943 to 1.18 percent in 1966.⁷

Underlying sites and probable sources of sepsis in our twenty patients are listed in Table 2.

Staphylococcus aureus was the leading infective agent in our series, affecting eight of 13 cases in which organisms were isolated (Table 3). Twenty-three of Flaxman's 29 cases were of staphylococcal origin, but 32 years later, Kim had more fungal than staphylococcal cases: 24 with candida versus 23 with staphylococci.^{2,6} Twenty-six of Kim's 63 patients had been immunosuppressed with steroids (12 cases), anti-metabolites (9 cases), and radiation therapy (5 cases). Candida was the leader in a spectrum of infecting organisms which included clostridia, streptococcus faecalis, and bacteroides, reflecting the evolution of differing microbiologic

"Myocardial abscess may occur in any patient with overwhelming infection. Such infections are not rare in patients who are immunosuppressed by steroids and anti-neoplastic chemotherapy, and in some cardiac surgical patients."

"Septicemia was the major precursor of myocardial abscess. Fifteen of our 20 patients were septicemic. *Staphylococcus aureus* was the leading infective agent in our series, affecting eight of 13 cases in which organisms were isolated."

Table 1
Distribution of Myocardial Abscess by Age Groups
(Decades)
10,651 Autopsies, 1931-1976

Decade	Number of Patients
9th	1
8th	7
7th	2
6th	4
5th	2
4th	1
3rd	1
2nd	0
1st	2
	<u>20</u>

Table 2
Possible Sources in 20 Patients
with Myocardial Abscess
10,651 Autopsies, 1931 - 1976

Findings	Number of Patients
Adenocarcinoma of Bowel (No infection at site of carcinoma, but infection at other sites)	3
Bronchopneumonia	6
Endocarditis	5
Pyelonephritis - chronic	1
Gangrene of foot	1
Peritonitis	2
Cholangitis	1
Meningitis	1
	<u>20</u>

Table 3
Organisms in 20 Cases of Myocardial Abscess
10,651 Autopsies, 1931 - 1976

Organism	Number of Patients
Staphylococcus aureus	8 (40%)
Pneumococcus	3 (15%)
Proteus	1 (5%)
Klebsiella and E. coli	1 (5%)
Organisms not cultured	7 (35%)
	<u>20</u>

susceptibilities in an era of open heart surgery, antineoplastic chemotherapy, chronic hemodialysis, and antibiotic resistance.

Immunosuppressed patients may be at particular risk for fungal myocardial infection and abscess. Buchbinder collected six such cases.⁸ All six had been treated with cytotoxic agents for lymphoma or leukemia. *Candida* was the agent in four, *mucor* in one, and *asperigillus* in one. There were four fully developed abscesses and two cases of mural endocardial infection without discrete abscess.

Our patient had a blood glucose of 244 mg/dl and a CO₂ of 12 mEq/L, suggesting that he might have been diabetic and acidotic. Although our review discovered no reported correlation between diabetes and susceptibility to myocardial abscess, there is a possibility that diabetes and acidosis made this patient more vulnerable to infection and subsequent abscess formation.

Two of our 20 patients had abscesses in the adipose tissue at the atrio-ventricular junction. Three others had abscesses at the level of the posterior mitral leaflet by direct extension from an underlying endocarditis. The remaining abscesses in our patients were scattered over various myocardial areas

with no particular pattern.

Abscesses seemed to form in healthy rather than previously infarcted myocardiums. Korns reviewed the reports of eight patients with abscesses who had had a previous myocardial infarction.⁵ Three of these eight died of myocardial rupture. Considering the high incidence of myocardial infarction and the rarity of myocardial abscess, it is probable that a previous infarction does not place a patient at added risk for developing a myocardial abscess. An abscess in a patient with a previous myocardial infarction increases the risk of sudden death from myocardial rupture, but precisely how much greater this risk is in patients with myocardial abscess superimposed on an infarction, than in patients with myocardial infarction alone, is not known. Canning's report of ten cases of myocardial abscess in patients with previous infarctions, collected up to January 1969, gave no answer to this question.⁹ Bates *et al.* reported a range of four to 24 percent for cardiac rupture in fatal acute myocardial infarctions recorded by 35 different authors from 1928 through 1973.¹⁰ Infective endocarditis and myocardial abscess were separate causes of rupture, but there was no comment about their relative frequencies when combined with previous infarction.

The myocardial abscesses in our patients usually were obscured by manifestations of underlying septicemia. The abscesses remained clinically silent. Cardiac rupture was accompanied by chest pain, hemopericardium, and tamponade—dramatic symptoms and signs, which ended in death. Antibiotic and other therapy never deterred the ultimate outcome. Our study showed no perceptible difference in incidence, and none in mortality, between the pre- and post-antibiotic eras, taking the year 1950 as a transitional point. There were eight fatal cases of myocardial abscess among 3,551 autopsies before 1950, and 12 fatal cases in 7,100 autopsies after 1950 (0.22 and 0.16 percent respectively).

Some patients demonstrated unusual features. Hackel and Kaufman described an 81-year-old man with septicemia due to *E. coli* who developed an abscess at the attachment of the anterior papillary muscle to the left ventricular wall.¹¹ The affected muscle ruptured. The patient died seven hours after admission to the hospital, having developed an apical systolic murmur and thrill, and an aortic systolic murmur. The authors found only two other cases of papillary muscle rupture in 11,550 autopsies at the Cleveland City Hospital from 1932 to 1952. This event now is well known as a complication of myocardial infarction, but forty years ago it was unrecognized by, if not entirely unknown to, most physicians.

Symbas *et al.* encountered a ventricular septal defect and three mycotic aneurysms of the mitral-aortic intervalvular fibrosa in four patients with bacterial endocarditis and myocardial abscesses.¹² The ventricular septal defect was caused by a pneumococcal abscess. Two of the three mycotic

“Antibiotic and other therapy never deterred the ultimate outcome. Our study showed no perceptible difference in incidence, and none in mortality, between the pre- and post-antibiotic eras, taking the year 1950 as a transitional point.”

aneurysms were caused by streptococcus viridans and klebsiella. No organism was isolated in the third patient. The klebsiella infection occurred in a 17-year-old male who had undergone surgery for idiopathic subaortic stenosis six months before admission, and a cardiac catheterization one month before admission. His blood cultures during life were negative, but klebsiella was cultured from post-mortem right ventricular blood.

Routine x-ray examination of the chest rarely showed any changes in our patients. There was enlargement of the cardiac shadow with pericardial effusion. Some electrocardiograms were consistent with pericarditis, pericardial effusion, or myocardial infarction, but they were often normal.

It is clear that physicians caring for such patients in the past were faced with an obscure process which was life-threatening, difficult to diagnose, and uniformly fatal, no matter what the therapy.

CONCLUSIONS

There probably will be an increase in the incidence of myocardial abscess over that shown in previous studies and in our own (20 patients in 10,651 autopsies in 45 years.) It already may have risen as a result of procedures which render patients susceptible to bacteremia and endocarditis while diagnosing and treating other illnesses. Physicians should be alert to the possibility of this diagnosis when there is pericardial effusion and tamponade, ventricular septal defect, or cardiac rupture. Although all reported confirmed diagnoses of myocardial abscess to date have been post-mortem, there is reason to predict that the diagnosis may now be made while the patient is living. The use of the Gallium scintigram may help establish this specific diagnosis when it is suspected. Therapy, if instituted earlier in the natural history of the disease, may become something more than the futile endeavor it has been to date.

SUMMARY

We analyzed 10,651 autopsies performed at the Jersey City

Medical Center from 1931 to 1976 and found 20 cases of myocardial abscess, usually in patients with catastrophic infections. They represented less than 0.187 percent of those autopsied. There was no undue frequency in patients with previous myocardial infarction. The commonest organism was Staphylococcus aureus. Clinical symptoms and signs were those of preexisting septicemia. Some patients had chest pain and signs of pericardial effusion and tamponade. No documented case was diagnosed during any patient's lifetime. New investigative methods, such as the Gallium scintigram, now may establish the diagnosis in living patients, and the heretofore ineluctably fatal outcome may improve with early treatment.

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CASE REPORTS

Doxorubicin Hydrochloride (Adriamycin®) and Related Soft Tissue Injuries

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With the expanded use of doxorubicin hydrochloride (Adriamycin®) as an antitumor agent, an increasing number of soft tissue complications have become evident. Three patients who have been followed during the last two years showed that early excision in an amount larger than one normally would expect will reduce the morbidity. The administration of the agent should be in a secure intravenous line and any evidence of loss into the tissues should lead to immediate cessation of administration.

Doxorubicin hydrochloride (Adriamycin®) infiltration into soft tissues can lead to destruction of the tissue. With the expanded use of doxorubicin hydrochloride (Adriamycin®) as an antitumor agent, an increasing number of soft tissue complications have become evident. In the following article, three cases which have been treated in the last two years are reviewed and possible methods of avoiding the complications and shortening the morbidity are discussed.

CASE REPORTS

Patient #1 (male) was diagnosed in November 1976 as having pulmonary adenocarcinoma involving the left upper lobe with diffuse parietal and distal metastases. After thoracotomy and pleural biopsy, the patient was started on chemotherapy with doxorubicin hydrochloride (Adriamycin®) given by intravenous bolus injection. In March 1977, he was referred for plastic surgical care of an eschar which had been present for approximately three months. A thick black eschar on the dorsum of the left hand measured five by seven centimeters (see figure one.) The eschar was debrided, but the extensor tendons and intact paratenon were left. The metacarpal phalangeal joints were noted to be fixed in extension. The patient was treated with whirlpool and topical Silvadene® therapy. Physical therapy for increased range of motion of the metacarpal phalangeal joints also was begun and multiple bedside debridements were performed.



Figure 1—Patient one—four months after extravasation.

Approximately one week after admission, early peripheral granulation was noted; however the paratenon and tendon progressed to necrosis. There was slight drainage with no evidence of infection. The patient continued to show slow improvement and sixteen days after admission (see figure two), he was taken to the operating room and a split

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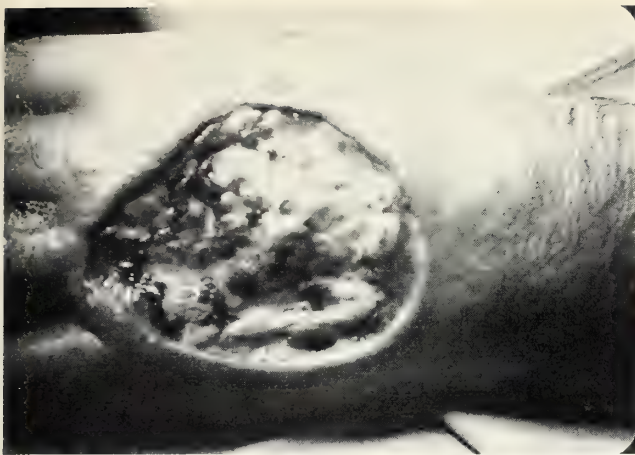


Figure 2—Patient one—after conservative debridement and preoperatively.



Figure 3—Patient one—six weeks after second surgery.

thickness skin graft was placed. The patient was discharged to be followed in the office.

Seven days after surgery approximately one-third of the graft was noted to be adherent. Although the wound was clean, vascularization of the grafts did not take place in the wound center. The patient was again begun on wet to dry soaks and the wound continued to granulate slowly. A second skin graft was applied two weeks after the initial surgery. Fifty percent of this second graft adhered; on May 2nd the defect measured approximately two centimeters in diameter with pale granulation noted in the defect. Over the next two weeks complete closure of the wound occurred by means of epithelization and contraction (see figure three). The metacarpal phalangeal joints remained in a fixed and extended position.

Patient #2 was a 66-year-old female who was treated with doxorubicin hydrochloride (Adriamycin®) by intravenous bolus injection for metastatic breast carcinoma. Approximately three weeks after the therapy, the patient developed a slough of the skin and soft tissue of the right volar forearm with exposure of muscle and tendinous structures. On her initial office visit, the defect measured approximately four by six centimeters with granulation in the center and an adherent eschar peripherally. The extensor indicis tendon was noted to be exposed. The patient was admitted to the hospital and debridement and split thickness skin graft from the right thigh to the forearm were performed.

Approximately 65 percent of the graft took primarily and the nongrafted area remained free of infection. The patient was placed on saline wet to dry dressings. During the next month the remainder of the wound healed by epithelization and contraction. The patient maintained a good range of motion of the fingers with her only loss being that of independent extension of the index finger.

Patient #3 was a 50-year-old female with carcinoma of the breast and known brain metastases. The patient was placed on doxorubicin hydrochloride (Adriamycin®) therapy and developed a left anticubital skin loss. Initial examination revealed a two centimeter in diameter necrotic ulcer at the flexion crease with peripheral swelling. The patient was taken to the operating room where debridement of the surrounding soft tissues was performed until normal appearing and bleeding tissue was noted. A split thickness skin graft was then applied with a complete take. The patient was discharged from care with no functional deficit.

DISCUSSION

Doxorubicin hydrochloride (Adriamycin®) is a cytotoxic antibiotic agent isolated from cultures of *Streptomyces peucetius* var. *Caesius* which binds to DNA and thereby inhibits nucleic acid synthesis. Pharmacokinetic studies have shown significant tissue bonding. After administration, approximately five percent of the drug is excreted in the urine during the next five days and 40 to 50 percent is excreted in the biliary tract during the next week. In 1974, the ability of doxorubicin hydrochloride (Adriamycin®) to reactivate the symptoms of radiation injury were reported by Donaldson *et al.* at Stamford University.³ They felt that this might have occurred due to a cumulative effect of cytotoxic effects of the doxorubicin hydrochloride (Adriamycin®) with the radiation. In 1975, Cohen *et al.*,² at the Fitzsimmons Army Medical Center, followed a patient who, having had an extravasation of doxorubicin hydrochloride (Adriamycin®), slowly began to heal the soft tissue defect. At a time that the defect was noted to be almost closed, the patient was given another dose of doxorubicin hydrochloride (Adriamycin®) in another extremity and had breakdown of the previously healing wound. This report also points out the strong possibility of the summation of cytotoxic effects.

In our three patients the initial injuries were noted and felt to be of less consequence than they turned out to be. The appearance of the wounds initially was such that spontaneous healing was felt to be the normal course. Time showed that these wounds did not heal and continued to enlarge, the extent of eventual tissue damage being underestimated. Whether this continued enlargement is due to a release of the doxorubicin hydrochloride (Adriamycin®) from the dead cells to harm other cells, which previously were normal, or

“Doxorubicin hydrochloride (Adriamycin®) is a cytotoxic antibiotic agent isolated from cultures of *Streptomyces peucetius* var. *Caesius* which binds to DNA and thereby inhibits nucleic acid synthesis.”

"... (Adriamycin®) should be given by the intravenous route slowly into the tubing of a free-running intravenous infusion of sodium chloride or of five percent dextrose. The injection should not take less than three to five minutes."

"When extravasation with slough is noted, early debridement of all involved tissues is mandatory."

whether this is akin to radiation injury, in which the previous normal-appearing tissue, over time, shows the effects from the initial injury, is yet to be determined. All three patients showed poor healing in the area of the slough, although active infection was no problem. In the initial case, an attempt at conservative therapy in order to save the tendon structures was fruitless. In the final case, wider debridement of the area resulted in a closure of the wound in a relatively short time.

Prevention is better than cure. Doxorubicin hydrochloride (Adriamycin®) should be given by the intravenous route slowly into the tubing of a free-running intravenous infusion of sodium chloride or of five percent dextrose. The injection should not take less than three to five minutes. Even though blood returns from aspiration of the intravenous tubing, the injection should cease if the patient notes a burning sensation in the area of infusion. This burning sensation denotes an extravasation of the doxorubicin hydrochloride (Adriamycin®) into the soft tissues. The infusion should be preferentially started in an area where, if extravasation should occur, the structures would lend themselves to debridement with less functional loss. A desirable area is the muscular portion of the forearm away from tendons and joint spaces.

When extravasation with slough is noted, early debridement of all involved tissues is mandatory. This certainly will decrease the time involved to obtain closure, although it may not decrease the amount of tissue that has to be excised.

Once a slough due to doxorubicin hydrochloride (Adriamycin®) has occurred, it is recommended that this agent be removed from the therapeutic regimen so that a recrudescence of the problem does not occur.

SUMMARY

Doxorubicin hydrochloride (Adriamycin®) therapy must be given cautiously through the intravenous route in the tubing of a reliably flowing intravenous infusion. Any burning symptoms may indicate loss into neighboring soft tissues. Necrosis calls for early debridement of all tissue to a viable level. There is a tendency to underestimate the amount of tissue needed to be excised which leads to an increased morbidity for the patient.

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Burkitt's Lymphoma Presenting With Intestinal Intussusception

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Five patients with Burkitt's lymphoma presented at our hospital over a four-year period. In two of the patients the tumor was the lead point of an intestinal intussusception. Diagnosis and management of this tumor, which is being seen more frequently in the United States, is discussed thoroughly.

Burkitt's lymphoma, which currently is classified as malignant lymphoma "undifferentiated, Burkitt's type,"¹ first was described by Burkitt in 1958 as a lymphoma found in African children involving the jaw and abdominal viscera.² Since the initial description from tropical Africa, Burkitt's lymphoma has been found to occur with increasing frequency in many other countries including the United States.³ Because of this, a registry was initiated in 1972 and over the next three years, 114 American cases of Burkitt's lymphoma have been documented.⁴ We present a somewhat unique experience from a community hospital including two cases in which Burkitt's lymphoma acted as the leading point of an intussusception.

CASE REPORTS

1. A 10-year-old male was in good health until September 1977, when he developed streptococcal pharyngitis which was treated with oral penicillin. A few days later, he developed vomiting and diarrhea with intermittent abdominal pain without fever, and was admitted to the hospital for evaluation and treatment. Because of increasing lethargy, a spinal tap was performed with normal results. Following rehydration, he was sent home with a diagnosis of viral gastroenteritis with meningismus. He did well until the beginning of November 1977, when lower abdominal pain with intermittent vomiting and diarrhea recurred. Physical examination revealed a softly distended abdomen with high-

pitched bowel sounds suggestive of intestinal obstruction. No masses were palpated. Laboratory data showed: hematocrit, 36%; WBC, 9,600 with 56 polys and 16 bands. Electrolytes were normal. Abdominal x-rays showed multiple dilated small-bowel loops with air-fluid levels present. Barium enema then was performed which revealed ileocecal intussusception (figure 1). After stabilization with intravenous fluids and nasogastric suction, he was taken to the operating room. An ileocecal intussusception was found and manually reduced. The mesenteric lymph nodes were immensely enlarged and there were numerous multiple nodular metastases in the liver. A small bowel resection with primary anastomosis was performed; the procedure was well-tolerated. A bone marrow biopsy and repeat spinal tap were negative. In the postoperative period he was admitted to a

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Figure 1—Barium enema roentgenogram demonstrating ileocecal intussusception (case 1).

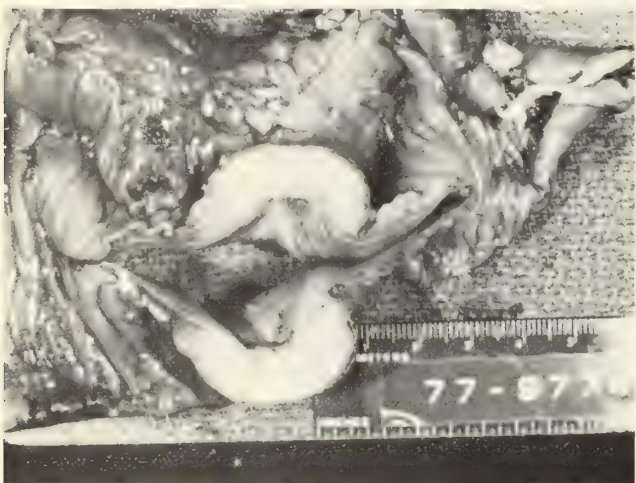


Figure 2—Bisected, polypoid Burkitt's lymphoma of terminal ileum demonstrating transmucosal involvement (case 1).

special chemotherapy protocol study and treated with cyclophosphamide (Cytoxan®), vincristine sulfate (Oncovin®), prednisone, and methotrexate. A second abdominal operation showed no disease in December 1977. He was well and without progression of disease in January 1978.

Gross Pathology—The segment of terminal ileum measured 17.0 cm. in length. A polypoid, ulcerated 3.5 x 2.0 x 2.0 cm. mass, composed of grey tissue, infiltrated the entire wall of the ileum (figure 2).

Diagnosis—Burkitt's lymphoma of the terminal ileum and mesenteric lymph nodes. (See figure 5.)

2. A 17-year-old female noticed a mass in her left submaxillary area for three to four weeks; it originally was thought to be an abscess and was treated with antibiotics without response. She was admitted to the hospital on January 31, 1974. Biopsy of a 3 x 2 cm. necrotic lymph node showed Burkitt's lymphoma. Intestinal obstruction developed on the third hospital day and at laparotomy, a mass in the stomach and three separate small intestinal masses were found and resected. A splenectomy and multiple liver biopsies also were performed. The postoperative course was complicated by a left subphrenic abscess requiring reexploration and lysis of adhesions. Bone marrow biopsy was negative. Hospitalization lasted two and a half months. Following recovery, she received standard chemotherapy. She was hospitalized in

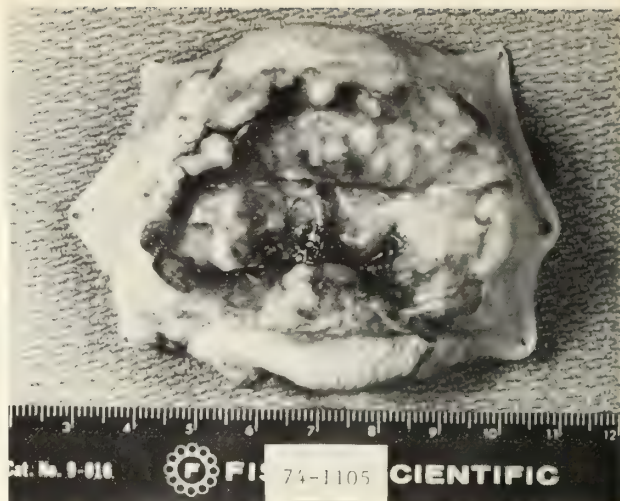


Figure 3—Partial gastrectomy with excavated lymphomatous mass (case 2).



Figure 4—Polypoid, lymphomatous intussusceptum (right) and smaller, sessile lesion of small intestine (left) (case 2).

1976 for treatment of a tubo-ovarian abscess. Follow-up at present shows her to be well and living in Colorado.

Gross pathology—The partial gastrectomy contained a 7.0 x 5.0 x 2.5 cm. raised, partly excavated tumor composed of grey, soft tissue which infiltrated the wall (figure 3). The separate segments of small bowel measured 30.0 and 18.0 cm. The larger demonstrated an intussusception, the lead point of which was a polypoid, partly ulcerated 7.0 x 4.0 x 4.0 cm. tumor (figure 4). A separate bowel tumor measuring 2.5 cm. was also present. The other segment of small intestine showed two separate tumors measuring 2.5 and 2.0 cm. The spleen weighed 162 grams and a single 0.3 cm. grey nodule was found on serial sectioning. The liver biopsies were negative for tumor.

Diagnosis—Burkitt's lymphoma of stomach, small intestine (multifocal), spleen, perigastric and mesenteric lymph nodes. (See figure 5.)

3. A 28-year-old male developed a mass in the neck in 1971; it apparently receded. In 1972, he had melena and a duodenal ulcer was diagnosed by gastrointestinal x-ray series. In July 1976, a neck mass was biopsied and Burkitt's lymphoma was found. Laboratory studies, including bone marrow biopsy, liver scans, upper gastrointestinal series, and barium enema were negative. He was treated with cyclophosphamide (Cytoxan®) and the cervical mass disap-

"Burkitt's, lymphoma, which previously was thought to be peculiar to Africa, and was referred to in the literature as 'the African lymphoma,' is now recognized in the United States."³

"In children, intussusception is the leading cause of obstruction and ranks second to appendicitis as the cause of acute surgical abdomen."⁷

peared. In October 1976, a 1.5 cm. subcutaneous mass in the left forearm appeared; excisional biopsy revealed it to be Burkitt's lymphoma.

He then was transferred to the National Cancer Institute, where studies showed a negative bone marrow biopsy, but radiogallium scan revealed abdominal uptake. An intravenous pyelogram showed left ureteral displacement. He was treated with prednisone, vincristine sulfate (Oncovin®), methotrexate, and procarbazine hydrochloride (Matulane®). Initially he showed a good response with apparent complete resolution of tumor. In January 1977, he presented with a presternal mass and jaw pain. Bone marrow study showed invasion and circulating Burkitt cells. Despite multiagent chemotherapy, he developed central nervous system involvement and died on April 14, 1977.

Autopsy demonstrated extensive visceral and reticuloendothelial infiltration by Burkitt's lymphoma. The immediate cause of death was acute hemorrhagic bronchopneumonia.

4. A 29-year-old accountant was hospitalized in April 1976, with sudden onset of a mass in the left side of the neck which appeared approximately three weeks prior to admission. It originally was treated as an abscess, but later seemed to be a non-inflammatory tumor mass. A radiogallium scan showed increased uptake in the left neck, the left upper quadrant, and the mid abdomen. Biopsy of the 9 cm. mass showed Burkitt's lymphoma. The patient was treated with chemotherapy and was in remission in late 1977.

5. A 17-year-old female, one of eleven children, had lived all her life in Summit (New Jersey) until she moved with her widowed mother to Florida in June 1977. In the fall, severe back and sciatic pain led to a myelogram and laminectomy in Florida for a herniated nucleus pulposus at L5-S1. No other abnormal tissue was seen or removed.

Several severe throat infections led to the discovery of an abnormally enlarged tonsil and tonsillectomy was performed here in March 1978. Histologic examination revealed typical pyrenophilic sections of Burkitt's lymphoma.

Liver, bone, and gallium scans, lymphangiogram, and pelvic sonogram have failed to reveal any other site of disease. She currently is being evaluated for a chemotherapeutic protocol.

Microscopic Pathology—Tumor imprints from fresh tissue of all five cases were examined with Wright's stain. Most tissues were fixed in Bouin's solution and sections were stained with hematoxylin and eosin, periodic acid-Schiff reagent, with and without predigestion with diastase, and methyl green-pyronine Y.

The lymphomas of all five patients were identical and met the histological criteria for Burkitt's type.²⁰ They were composed of a diffuse, undifferentiated population of mononuclear lymphoid cells with a "starry-sky" pattern due to the presence of benign phagocytic histocytes (figure 5).

Mitotic figures frequently were seen in the lymphoma cells. Cytologically, these cells contained two to four nucleoli and an amphophilic cytoplasm which showed moderate, diffuse, uniform pyroninophilia and little appreciable glycogen. No lymphocytic maturation was observed.

DISCUSSION

Burkitt's lymphoma, which previously was thought to be peculiar to Africa, and was referred to in the literature as "the African lymphoma," is now recognized in the United States.³ These lymphomas in both geographic areas are histologically identical,^{6,23} although clinical differences are present. In Africa, the peak incidence in endemic areas of occurrence is below 12 years of age, while older patients have been diagnosed in the United States, especially in the 16 to 18-year-age group. In those cases reported in the American Registry, there is less of a predilection for jaw involvement, whereas abdominal involvement is very common; it occurs in approximately 60 percent of cases.⁵ For this reason, we have avoided using the staging criteria of the African cases. Both the African and non-endemic cases are characterized by a very rapid onset and a rapidly fatal course if untreated, although differences in late relapse after chemotherapy have been seen.¹

In children, intussusception is the leading cause of obstruction and ranks second to appendicitis as the cause of acute surgical abdomen.⁷ However, in comparison to adults, leading points for the intussusception are much less frequent in children, with the etiology being idiopathic in greater than 90 percent of cases.^{8,9}

In adults, it is not unusual for small bowel tumors, including lymphoma, to act as the lead point for an intussusception with the incidence approaching 10 to 15 percent in some series.^{10,11} However, in 427 reported cases of Burkitt's lymphoma, only one patient from Burkitt and O'Connor's original series in 1961 presented an acute abdomen secondary to intussusception.^{1,3,4,12-14} In five recent large series describing intussusception in over 1300 children, only eight lymphomas were reported and none was described as a Burkitt type.^{15,16} Two other earlier series by Faulkner and Mestel reported a greater occurrence of leading points in childhood intussusception secondary to lymphosarcoma (13 out of 46 cases).^{17,18} It is conjectural whether some of these cases of childhood lymphosarcoma included Burkitt's type. In Dorfman's autopsy study of lymphosarcoma in children from the St. Louis area, 14 cases demonstrated many histological features thought to be diagnostic of Burkitt's tumor.¹⁹ We consider our two case reports of intussusception in children to be unusual clinical presentations and our experience in a community setting for Burkitt's lymphoma as unique.

Survival in Burkitt's lymphoma patients is predicted by the

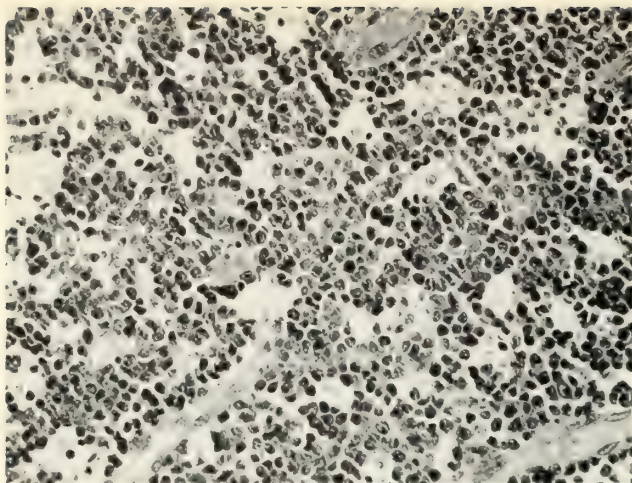


Figure 5—"Starry sky" pattern in undifferentiated lymphoma of the Burkitt's type found in all four cases (Hematoxylin and eosin, $\times 150$).

clinical pathological staging. An apparent cure is obtained when patients remain free of disease two years following onset of therapy.

SUMMARY

Five new, American cases of Burkitt's lymphoma are described from the recent experience in a teaching, community hospital. Two of the patients presented in an unusual fashion with intestinal intussusception. Review of the American experience, current therapy, and prognosis is discussed.

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Delayed Pulmonary Metastasizing Synovial Sarcoma

ELMER N. MATTIOLI, M.D., Vineland

This case report of synovial cell sarcoma metastasizing to the lung after 20 years represents the longest known and reported case of its kind in the medical literature. The treatment consisted of lobectomy. The case is documented and the diagnosis is confirmed.

Synovial cell sarcoma, a very malignant and frequently fatal cancer, is a tumor of the somatic soft tissues involving the synovial tissue. There is, however, a wide range in the degree and potential for malignancy.¹ We report such a case in a patient with pulmonary metastasis recognized twenty years after the original diagnosis was made.

CASE REPORT

A 48-year-old male was admitted to the hospital in January 1976, for a "coin lesion" of the right lower lobe of the lung. The patient had been asymptomatic since 1955 when he underwent a right mid-thigh amputation for synovial sarcoma of the right knee.

Physical examination was negative. The usual preoperative tests were normal including the brain and bone scans. Blood chemistry was within normal range.

Following a right lower lobectomy, the patient was discharged. Final pathology report and the microscopic examination revealed sections of the lung containing spindle cells uniform in size, separated by thin stalks. Calcification was seen in the tumor. Hilar lymph nodes showed noncaseating granulomata consistent with Boeck's sarcoid origin.

DISCUSSION

The extremities, including the knee, foot, ankle, wrist, and forearm, are common sites for synovial cell sarcoma which generally occurs in the third decade of life. Physical findings

of the disease, which may be present from one to three years before diagnosis, may be limited to a painful mass in the area of the joint. Roentgenograms usually reveal a homogenous mass of soft tissue; eventually they show dense areas of calcium and, rarely, of bone.²

The gross pathology of the disease indicates that this is a firm, rapidly growing collagenous stroma frequently involving the joint capsule and even the tendon sheath. Basically, two types have been demonstrated histologically: pseudoepithelial and fibrosarcomatous. The spindle cell or fibrosarcomatous component is more malignant than the pseudoepithelial. Also, the spindle cell type may metastasize early and rapidly.³

Radical local resection, including amputation above the tumor, is often the treatment of choice. Pack and Ariel report a recurrence rate of as much as 63 percent following only local resection.⁴ Further treatment includes radical lymphadenectomy for metastases which, according to Campbell, developed as much as 17 years after the primary tumor was excised.⁵

Our case represents one of the longest periods on record, twenty years, for metastasizing synovial sarcoma of the knee.

In another case, a 15-year-old girl who presented with synovial sarcoma of the head and neck had several metastatic

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lesions removed from the neck and thyroid. Ten years later a metastatic lesion was noted in the left lung.

TREATMENT

Treatment for disease of the head and neck included excision alone, excision and radiation, and chemotherapy and irradiation.⁶

Lee, Hajdu, and Exelby reported 24 cases of childhood synovial sarcoma treated with wide excision or amputation. Four patients with pulmonary metastases had resection and chemotherapy; the results, however, were inconclusive. Twelve patients in the group developed pulmonary metastases.⁷

Generally, there has been poor response to treatment of synovial sarcoma with multiple drug therapy alone or in combination with radiation therapy. The drugs utilized include 5 fluorouracil, vincristine, cyclophosphamide, and methotrexate.⁸

Hill, Larsen, and Cohen reported 603 courses of therapy for solid malignant tumors with only 30 percent response.^{9,13}

Chromosomal abnormalities were noted in the white blood cells of patients with advanced nonhematopoietic malignancies receiving radiotherapy and chemotherapy. These included patients with synovial sarcoma treated with cyclophosphamide. It was assumed that the chromosomal changes in white blood cells probably were due to therapy rather than the neoplasm itself.¹⁰

Intensive cyclophosphamide therapy for synovial cell sarcoma resulted in some clinical remission with moderate to good response. One patient with synovial sarcoma of the knee presented three years later with metastases to the lung. Despite therapy with cyclophosphamide, the patient died three years later.¹² Synovial sarcoma also has been treated actively with bleomycin.¹⁴

The use of cytembena in the treatment of synovial sarcoma shows minimal effect and regression; however, remissions or subjective relief were seen in 39 percent of patients with skeletal metastases.¹¹

CONCLUSION

In cases of synovial cell sarcoma of the soft tissues, radical

local resection offers the greatest promise for long-term control. By contrast, chemotherapy appears to have only limited value in treating this disease.^{15,16}

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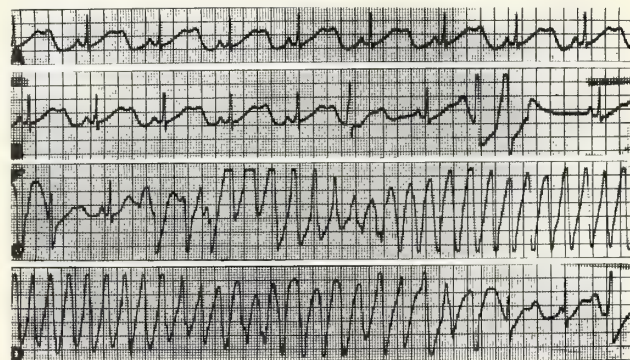
Torsade de Pointes

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Monitor strips A through D represent a continuous recording in a 42-year-old man with a long history of serious ventricular arrhythmias owing to the Romano-Ward syndrome, i.e., congenital QU prolongation, paroxysmal ventricular arrhythmias, syncope, and sudden death in the absence of deaf-mutism. Identical ECG abnormalities when associated with deaf-mutism constitute the Jervell-Lange-Nielsen syndrome. Strips A and B show a normal sinus rhythm with prominent U-waves, a very long QU interval and three ventricular premature impulses. Strips C and D demonstrate the abrupt onset and termination of a polymorphous ventricular tachycardia whose QRS complexes undulate in a bizarre fashion.

Though poorly and inadequately recognized in the English literature, this atypical form of ventricular tachycardia has been characterized elegantly by Dessertenne and others in French reports where it has been referred to as torsade de pointes, i.e., twisting points or heads. This arrhythmia is an unusual form of ventricular tachycardia characterized by bizarre undulation of polymorphous, ectopic QRS complexes and marked QU prolongation in sinus impulses. Torsade de pointes must be identified promptly and distinguished from classical ventricular tachycardia because it often deteriorates quickly to fatal ventricular fibrillation and because treatment with conventional antiarrhythmic drugs with quinidine-like membrane effects may prove disastrous.

In a retrospective study, I identified repetitive torsade de pointes in 16 patients admitted to a 12-bed CCU over five years. This mechanism was engendered by hypokalemia in four patients, quinidine overdosage in three, variant angina in two, idiopathic trifascicular block in two, and bradycardia syndrome, thioridazine poisoning, competitive pacing, sub-

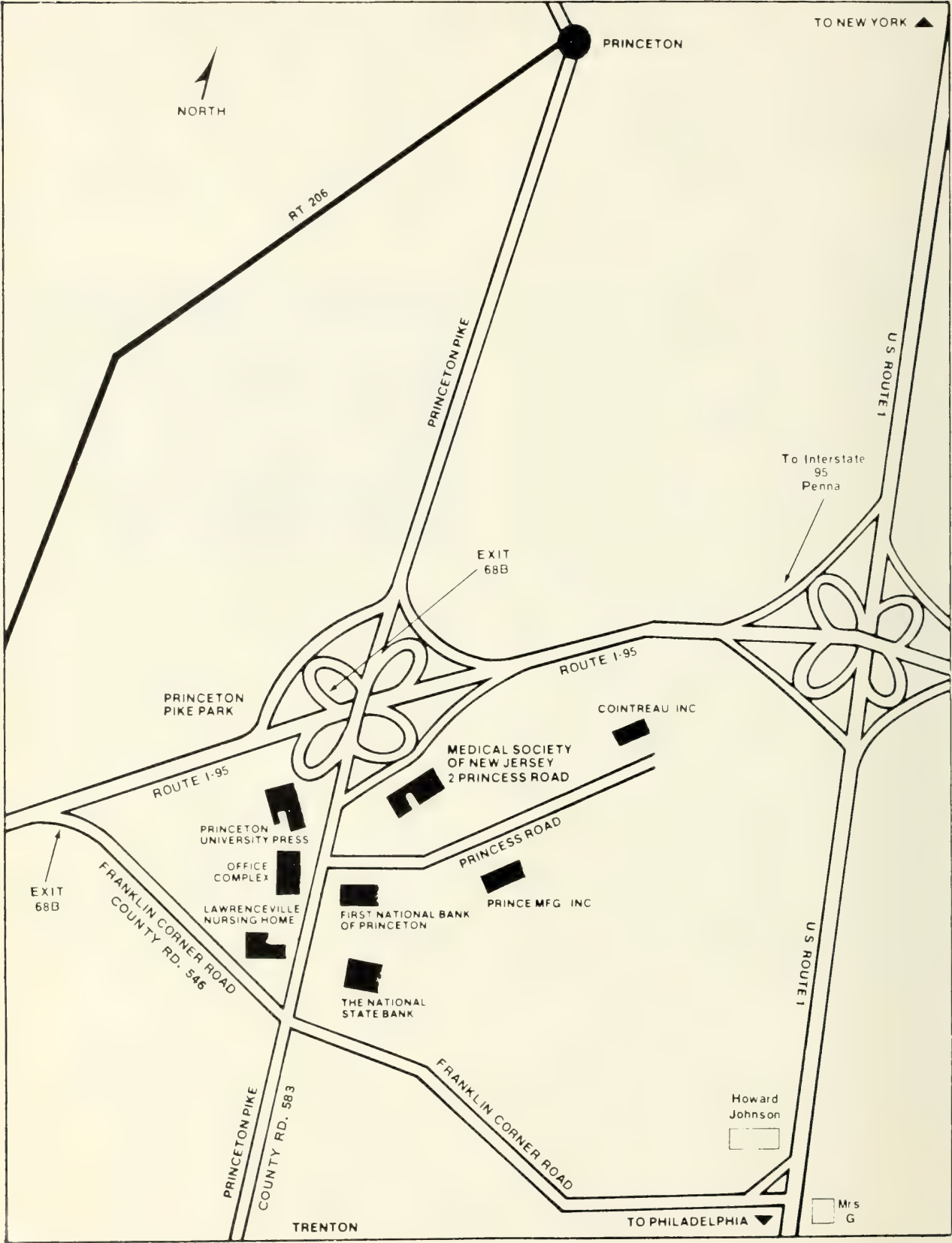


arachnoid hemorrhage, and the Romano-Ward syndrome in one case each. Six patients died in ventricular fibrillation despite withdrawal of the offending agent, potassium replacement, and cardiac pacing.

In essence, torsade de pointes is an ominous form of ventricular tachycardia that occurs in a variety of settings linked by QU prolongation. Rational therapy depends on recognition of the cause, avoiding quinidine-like "membrane" drugs, potassium replacement where indicated, and cardiac pacing. More controversial therapeutic endeavors include the use of drugs like isoproterenol, diphenylhydantoin, propranolol and quanehtidine as well as stellate ganglion blockade and ganglionectomy.

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Area Map—MSNJ Headquarters



Sugar and Disease

T.S. DANOWSKI, M.D., Pittsburgh*

What is the role of sugars, if any, in malnutrition, overweight, diabetes mellitus, hypoglycemia, and atherosclerosis?

MALNUTRITION

There is no evidence that sugar—whether sprinkled on grapefruit, stirred in coffee or tea, mixed in a dessert or eaten as a between-meal snack—can cancel the nutritive value of a food or a perfectly adequate diet. Therefore, only when a refined sugar such as sucrose interferes with or replaces a normal diet does it become an inadequate food item and only then does it deserve the designation of “empty calorie” to indicate that it lacks vitamins, minerals, trace elements, and so on. Under these circumstances, it can become the cause of nutritional deprivation.

OBESITY

There are persons who overeat because they particularly enjoy sweets and cannot control their intake of desserts and other foods which contain carbohydrates. Their fundamental problem is an unregulated appetite and/or a poor or absent satiety response. However, there are obese persons who do not relish or who even avoid carbohydrates and sweets but, nonetheless, end up consuming an absolute or relative excess of wholesome foods.

In individuals whose caloric excess does and does not include carbohydrates and sugars, the obesity often defies a permanent solution. Intermittent but nonsustained losses of weight often are achieved by eliminating desserts, starches or sugars and, hence, to the uninitiated, it is the sugars and starches and not overeating that are blamed for the obesity. Their obesity carries with it the long-recognized risks of hypertension, atherosclerosis, gallbladder disease, arthralgia, depression, and diabetes mellitus.^{1,2}

DIABETES MELLITUS

Does a high intake of carbohydrates, sugars, or sucrose, in particular, initiate diabetes?

In the current scientific view, diabetes develops largely in those older adults who become obese. Thus, diabetes in such persons almost always is accompanied by overeating. Once the fasting blood glucose reaches about 115 mg percent in such persons, there is a delay in insulin release.³ At that point, the reversible hyperglycemia of obesity meets the criteria for diabetes; namely, undue and prolonged fasting and/or post-prandial hyperglycemia attributable to deficient insulin supplies or actions. Also, in such persons neither the hyperglycemia nor the release of insulin in response to food

or enteric hormones produces the usual prompt suppression of hepatic glucose output.⁴ Moreover, insulin does not exert its usual glucose-lowering effect in the tissues.⁵

However, not all persons with severe lifelong obesity develop diabetes. This raises the possibility that those who do become diabetic have pancreatic islets with a genetic or other predisposition to diabetes or that the islets have been damaged by an environmental factor such as a virus. To date, an inherited weakness of pancreatic islets and/or a susceptibility to viral cell damage to islets has been associated with several genetic patterns in loci A, B, C and D of chromosome 6 in the juvenile-onset diabetes only.⁶ There is little evidence of diabetes, i.e., only five percent or so, in the parents and siblings of those with the juvenile-onset and insulin-dependent type. This is not true of the three-generation and other familial diabetes which appears in the later years of life and has a far more definite hereditary tendency. Thus, about one-half of patients with late adult-onset diabetes have siblings, parents, and other close relatives with diabetes.⁷

Obviously, once diabetes is present, with or without obesity, overeating of protein, carbohydrate, or sugars raises the blood sugar and, hence the diabetic diet quite appropriately restricts the total calories including those from carbohydrates. Sucrose is restricted only because it precludes the use of other palatable and nutritious carbohydrates. It is to be noted, however, that in some patients with treated diabetes, increasing the carbohydrate intake improves the insulin response to food.⁸

In most instances of obesity-related diabetes, even a limited but sustained weight loss diminishes or eliminates the diabetes as long as the weight loss persists.⁹ Hence, this late adult-onset diabetes is related to the excess of body fat resulting from a relative or absolute excess of caloric intake irrespective of the proportions of protein, fat, and carbohydrate.

Uncontrolled hyperglycemia may be responsible for (a) accelerated atherosclerosis, coronary heart disease, and strokes, (b) universal thickening of capillary basement membranes with resultant retinopathy and renal glomerulosclerosis and perhaps idiopathic cardiomyopathy, and (c) the neuropathies of diabetes mellitus.¹⁰ Also, high

*Reprinted with permission of *Contemporary Nutrition* 3:12 (December) 1978, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Danowski is Chief of Medicine, Shadyside Hospital and Clinical Professor of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania.

blood sugar levels may be the cause of a legion of other aberrations in diabetes. The length of the list precludes citation.

The above changes are most prevalent in insulin-dependent diabetes, an entity in which precise control of the blood sugar is almost never achieved by current insulin and diet regimens and may require self-measurement of blood glucose and four daily doses of insulin.¹¹ There is no evidence, however, that dietary carbohydrates play a key role in this intransigent type of hyperglycemia.

LOW BLOOD SUGAR (HYPOGLYCEMIA)

Carbohydrates also have been blamed for low blood sugar. There are two types of hypoglycemia, fasting and reactive. Fasting hypoglycemia is rare, while reactive hypoglycemia is most often a normal response in a healthy person. Fasting hypoglycemia results from one or more of six disturbances of glucose homeostasis.¹² It results from: starvation in newborns and occasionally in adults, malabsorption of carbohydrates or their precursors, decreases in liver glycogen or its release, decreased formation of glucose by the liver, increased glucose utilization not attributable to insulin and increased glucose utilization as a result of insulin excesses. Hence, none of the above-stated causes of fasting hypoglycemia can be ascribed to excess carbohydrate or to sucrose.

The reactive type of hypoglycemia indicates a reaction to the ingestion of food (including sugar). Three mechanisms may contribute to reactive hypoglycemia: transient delays in liver glucose output when the blood sugar returns to normal, transient delays in the clearance of insulin secreted in response to food or sugar, and transient delays in or absence of counter-regulation by glucagon, cortisol, growth hormone and/or epinephrine. Such reactive hypoglycemia can occur in persons with a perfectly normal glucose tolerance, glucose intolerance of the chemical diabetes type, and especially with a lag tolerance curve or a flat glucose tolerance.

Reactive hypoglycemia is usually entirely without symptoms and is a variation of normalcy, occurring in 20 percent of non-obese and 30 percent of obese control subjects.¹³ It may produce symptoms appropriate to a low blood sugar including transient hunger, lightheadedness, palpitations and sweating. This is more apt to occur with the lag type of chemical diabetes. However, there are some persons in whom the symptoms and signs of reactive hypoglycemia trigger a ripple effect of fatigue, emotional depression, or "sinking feelings." These ripple effects cannot be attributed to low blood sugar because they are not relieved by sugar and continue long after the blood sugar has returned to normal. Such ripple effects are more frequent in persons with difficulties in coping with or resolving school, marital, job, sex, aging or other problems.¹²

There are some therapists and persons who point to reactive hypoglycemia as the cause of ripple effects but there is no evidence for this. However, when the low blood sugar triggers the ripple effect, a low carbohydrate-high protein diet affords variable relief. Those with a ripple syndrome also require gentle, considerate, and wise management and counseling in addition to restriction of carbohydrate and sucrose. Undue emphasis on carbohydrates, particularly sugars, and sucrose defers attention to underlying chemical diabetes or emotional problems in complicated lives.¹²

Therapy in those with chemical diabetes should include weight loss in the obese and other measures to return glucose

tolerance to normal.

ATHEROSCLEROSIS

It is true that both diabetes and obesity due to caloric excesses (be they of carbohydrate or other origin) predispose persons to high plasma cholesterol, high low-density lipoprotein (LDL) cholesterol, low high-density lipoprotein (HDL) cholesterol and to high plasma very low-density lipoprotein (VLDL) triglyceride levels.¹⁴ However, only in the last of these, hypertriglyceridemia, can the intake of carbohydrates, including sucrose or other sugars play a specific role, i.e., a role apart from caloric excesses. Thus, some persons are sensitive to a high carbohydrate intake and develop a carbohydrate-induced hypertriglyceridemia while others are related to a high fat intake.¹⁵

The frequency of atherosclerosis is increased by obesity and diabetes, neither of which is directly related to sugar intake. Even in the case of the specific carbohydrate-induced hypertriglyceridemia, it is not possible to draw a clear cause and effect relationship between atherosclerosis and hypertriglyceridemia and sucrose intake. In women, high triglyceride levels of any origin significantly increase the frequency of vascular events including coronary heart disease, myocardial infarctions or strokes. In males, however, hypertriglyceridemia is not a risk factor with respect to vascular catastrophes unless hypertension, smoking and/or glucose intolerance are present.¹⁶ Hence, in carbohydrate-induced hypertriglyceridemia, gender also plays a key role in determining susceptibility to vascular disease.

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Selected Abstracts with Comments *

Bickers Rex G, et al: Combined aspirin/acetaminophen intoxication. *J Pediatr* 94:1001, 1979.

A child is reported with non-fatal intoxication due to the combined effects of these drugs. They were used alternately. Toxic illness can occur with therapeutic use of either of these drugs. Treatment of combined intoxication, when one cannot be sure which is causing what, is extremely difficult. "Only one study has investigated (this) regimen and it generated many unanswered questions . . . the question of pharmacologic interaction is unresolved. Until properly controlled studies have assessed the risk of combined aspirin/acetaminophen toxicity, we feel that the basis for prescribing such regimens is wholly inadequate."

Ward JI, et al: Hemophilus influenzae meningitis. *N Engl J Med* 301:122, 1979; Smith AL: Is Hemophilus Influenzae Meningitis Contagious? *N Engl J Med* 301:155, 1979, editorial.

In a study of household contacts of children with H. influenzae meningitis, the risk was assessed for development of severe H. flu disease within the subsequent 30 days. The risk in household contacts under age one was six percent! The risk under age four was two percent. The risk above age six was nil. The risk to household contacts under age six is approximately 600 times normal and is equivalent to the risk of meningococcal contact. Most secondary cases occur within the first week. The use of Rifampin in the usual anti-meningococcal prophylactic dose is suggested for current use until further data are generated.

Comment: This study suggests that all household contacts of H. influenzae under age six be observed carefully for the subsequent month. I would agree that they should receive Rifampin as immediate prophylaxis.

Murphy D et al: Treatment of ampicillin resistant H. influenzae in soft tissue infections with high doses of ampicillin. *J Pediatr* 94:983, 1979.

Good clinical responses were observed in resistant H. flu bacteremia with epiglottitis, cellulitis, pneumonia and arthritis when treated with ampicillin alone (high dose, 200-400 mgm/kg/day, IV). Despite resistance, levels can be achieved in blood and soft tissues (not meninges) which exceed the MIC of these organisms.

Comments: Avoidance of the overuse of chloramphenicol is the issue. Non life-threatening possible H. flu disease (otitis media) is treated with ampicillin alone. Why not for, say, septic arthritis or pneumonia? Dr. McCracken in a commentary (*J. Pediatr* 94:987, 1979) states that

" . . . ampicillin should not be used alone for initial therapy of any pediatric infectious disease, with the possible exception of uncomplicated otitis media." He indicates that accompanying meningitis is common and cannot be ruled out by an initial normal tap. He recommends combined initial therapy until identification of the organism and its sensitivity. Despite my concerns re overuse of chloramphenicol, I agree with these persuasive arguments. Although ampicillin alone may be successful in resistant H. flu, the risks are too great.

Buxton AF et al: Contamination of intravenous infusion fluid: Effects of changing administration sets. *Ann Intern Med* 90:764, 1979.

The rates of IV-associated infections were compared when administration sets were changed every 24 versus every 48 hours. No differences were noted.

Comment: In IV administration, several mechanisms of infection are possible: (1) the fluid or tubing can be contaminated; (2) the catheter or needle can allow infection around them; (3) the catheter or needle can introduce infection. Careful attention to detail reduces the first possibility. This study suggests that daily replacement of tubing may be unnecessary. Careful technique of insertion helps with (2) and (3). If possible a needle should be used rather than a cannula (less phlebitis from the former) and the needle or catheter must be removed and replaced *at least* every 48 to 72 hours (unless "tunnelled" as in parenteral alimentation).

Dutt AK: Short course chemotherapy for TB with largely twice weekly isoniazid—rifampin. *Chest* 75:441, 1979.

For the first time, patients in the U.S. were treated with short course therapy. Three hundred fifteen patients received INH—Rifampin daily for one month and high doses twice weekly for eight additional months. There were only ten failures of 185 trials and only three relapses in 214 patients during a one to 27-month follow-up. Toxicity was minimal.

Comment: There have been multiple foreign trials of short course regimes and most have been successful. This study confirms those. The savings in drug costs and gratification of patients is substantial. These patients had moderately far advanced disease and did well. The application of these data to the routine treatment of TBC in the U.S. should be seriously considered.

*Abstracted from "Children's Hospital Newsletter," United Hospitals of Newark, Vol. 1, No. 8 (August 1979). Selections are made and original comments prepared by Richard H. Rapkin, M.D., Medical Director, and members of the medical and surgical staff.

Keighley MRB, et al: Comparison between systemic and oral antimicrobial prophylaxis in colorectal surgery. *Lancet* 1:894, 1979.

Oral prophylaxis was far less effective than systemic in a prospective randomized trial. Oral administration of prophylactic antibiotics in colon surgery increases the risks of bacterial resistance, superinfection and antibiotic-associated colitis.

Comment: More details on elective surgery of the colon prophylaxis. The evidence is strong that antibiotics when given just preoperatively and for one or two doses postop have good effect. The choice should be appropriate to cover anaerobes and aerobic gram negatives (metronidazole and kanamycin were used in this study) and the route should be parenteral rather than enteral.

Manroe BL, et al: The neonatal blood count in health and disease. *J Pediatr* 95:89, 1979.

A careful study of normal and abnormal neonatal neutrophil counts was made. Neutropenia occurred in maternal hypertension, periventricular hemorrhage, severe asphyxia, and reticulocytosis at age 14 days or more, as well as in sepsis. "Only in the absence of other maternal intrapartum and neonatal factors that significantly alter neutrophil dynamics can values outside of the reference range be accepted as indicating infection." Immature neutrophil counts were less specific than neutropenia.

Comment: There are tables and graphs galore in this wonderful paper. Careful, even meticulous, detail will allow use of the data by all who care for newborns. The value of blood counts in possibly septic newborns is confirmed by this paper. A normal blood count is strong evidence against the presence of infection, state these authors.

Squire E, et al: Diagnosis of neonatal bacterial infection. *Pediatr* 64:60, 1979.

Thirty-nine newborns coming to autopsy had unequivocal infection proved at postmortem; 50 others had no evidence of infection. Premortem blood cultures of the non-infected were sterile in 48/50. Of the 39 with infection 32 had positive cultures (all were cultured). Of these seven patients, three had negative hematologic findings as well as negative cultures. Negative blood cultures may occur in the presence of significant (deadly!) bacterial illness.

Comment: Most neonatal bacterial infections have associated bacteremia of significant proportions. Neonatal patients with presumed sepsis are begun on appropriate therapy before knowing culture results. Upon report of a negative culture (two to three days later) the patient often has antibiotics stopped, usually because another cause for the "septic" picture has been identified. This report should not alter that process. The patients who died from infection who had negative blood cultures had those cultures drawn within a day or two of death (mean 13 hours). Antibiotics had not been stopped because of a negative culture. The use of antibiotics in the nursery is a two-edged sword. It is necessary to cure but overuse leads to harm. Careful evaluation of each patient is necessary.

Lloyd-Still JD: Chronic diarrhea of childhood and the misuse of elimination diets. *J Pediatr* 95:10, 1979.

One hundred eight children with chronic recurrent diarrhea were referred to a pediatric gastroenterologist. The average age was two years. Most children had benign conditions which spontaneously disappeared. In a sizeable

subgroup elimination diets had been tried for prolonged periods prior to referral and 70 percent developed significant weight loss. All children regained their weight loss within three to six months of returning to a normal diet.

Comment: Many children with chronic diarrhea are otherwise well. Davidson has labelled this chronic nonspecific diarrhea. The syndrome usually "abates" upon toilet training completion. Treatment of the symptom can be harmful. Recent evidence suggests that low fat diets can exacerbate the diarrhea and now Dr. Lloyd-Still points out that even more severe iatrogenic complications are possible. *Primum non nocere.*

Holaday JW et al: Naloxone reversal of endotoxin hypotension suggests role of endorphins in shock. *Nature* 275:450, 1978; **Faden AI, et al: Opiate Antagonists: A Role in the Treatment of Hypovolemic Shock.** *Science* 205:317, 1979.

Endorphin is likely released during shock states and may contribute to hypotension. Naloxone, in an animal model, rapidly reverses endotoxin-induced hypotension and also prevents its occurrence. The same findings are noted in experimental hypovolemic shock. The low toxicity of naloxone and its effect on shock in experimental animals makes it an attractive agent. Naloxone may be efficacious in septic shock and in hypovolemic shock.

Comment: Animals only so far, but these are fantastic data and raise wonderful possibilities. The soon to come primate data will be exciting to see.

Foy HM, et al: Long-term epidemiology of infections with mycoplasma pneumoniae. *J Inf Dis* 139:681, 1979.

Infection due to *M. pneumoniae* (MP) may be recurrent. The majority of MP infections are upper respiratory. Rates of pneumonia incidence with MP are greatest at ages five to nine while total pneumonia incidence is greatest from birth to age five. MP infection has a cyclic pattern with epidemic peaks. No seasonal influence is noted. Approximately one-third of all pneumonia in the age group five to nine is MP. Annually eight percent of age group five to nine are infected with MP; six percent of 15-19 year olds are infected. Ten percent of five to nine year olds with MP infection have pneumonia; two percent of 15-19 year olds with MP have pneumonia.

Morin CL, et al: One-hour blood xylose test in diagnosis of cows' milk protein intolerance. *Lancet* 1:1102, 1979.

D-xylose given as a ten percent solution in a dose of 14.5 grams/m² given po was measured in the blood after 60 minutes. Patients with milk intolerance had a drop of 50 to 80 percent from control levels after challenge with milk. The authors propose that a diagnosis of cows' milk protein intolerance requires: clinical disease on cows' milk; good clinical response to milk-free diet; a normal blood xylose (one hour) one month or more after clinical recovery; a significant fall in one hour blood xylose after a challenge.

Gurwith MJ et al: A prospective controlled investigation of prophylactic trimetoprim-sulfamethoxazole in hospitalized granulocytopenic patients. *Am J Med* 66:248, 1979.

Granulocytopenic afebrile patients (mostly with malignancy on chemotherapy) were allocated to prophylaxis or control group. No bacteremias occurred in the prophylaxis group (909 at risk days). In the control group there were nine bacteremias (796 at risk days). This study showed also that febrile days were reduced in the prophylaxis group (19

percent) versus the control (39 percent). Toxicity was minimal.

Comment: This study was in adults but its extrapolation to children seems warranted. Patients with granulocytopenia who are already febrile should be treated with first line antibiotics (see previous newsletter). Patients who are granulocytopenic and afebrile may benefit from this type of prophylaxis.

Wentworth, P. et al.: Analysis of sudden unexpected death (SUD) in southern Ontario. *Can Med Assoc J* 120:676, 1979.

All 2427 autopsies performed in two Ontario hospitals were reviewed.

Twenty-eight percent of sudden unexpected death (all age groups) were due to violence or poisoning. The major cause of SUD was coronary disease (43 percent). The major causes of SUD were:

	Age Group 20-49		
Cause	0-19	20-49	50+
Violence or poisoning	87	146	125
Coronary	1	56	505
Respiratory	9	14	147
CNS	1	7	62
Other (SIDS)	35	15	78
Myocarditis	3	10	7
Total	137	246	916

A remarkable finding was 20 patients with myocarditis. The majority of such patients were between ages 20 and 49 and had the characteristics of viral myocarditis.

Duff RS: Guidelines for deciding care of critically ill or dying patients. *Pediatr* 64:17, 1979.

This must-reading paper provides guidelines developed at Yale-New Haven Medical Center by one of the pioneers of medical ethical discussion and his colleagues. The guidelines

state the following:

1. The child's hospital record must designate a responsible physician.
 2. Parents may request a change in this physician. The responsible physician must ensure that decisions for care reflect child and family values. Supports of child and family as well as technical care excellence must also be ensured by this physician.
 3. Child's and parents' feelings, thoughts, values and wishes must be considered.
 4. The responsible physician will exercise judgment in a leadership role but must also function as a team member. The responsible physician and the team must attempt to define issues and decide care. The team will develop recommendations and then a full review will be carried out by the physician with the child and family before action (unless the action is an emergency).
 5. If there are major disagreements in the team the conflicting recommendations must be presented to the family.
 6. If not resolved, a conference of contending parties, often including family, must be convened. The power to decide remains first with the child and family and second with the responsible physician.
 7. If parents disagree with a proposed course of action their decision must be reviewed. Parents and medical authorities may seek legal counsel to resolve conflicts. "Paternalistic acts of whatever benevolent intent must not be imposed unless there is convincing reason to believe the preferred choice is inferior and an alternate one superior."
 8. Supporting personnel can better care for patients when plans, motives and values are understood. The critically ill or dying patient should be classified in the medical record. Reclassification at any time is appropriate. The classes are:
 - a. Maximal therapeutic effort without reservation.
 - b. Selective limitation of therapeutic measures.
 - c. Discontinuance of life sustaining therapy.
- Comment:** Please read the article.

Help for Impaired Physicians

Through its Committee on Impaired Physicians, MSNJ helps doctors who are suffering from alcoholism, other drug addiction, psychiatric disorders, or senility. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early and family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

HELP US TO HELP

Call the Physicians' Confidential Assistance Line (609-896-1884). Only specially trained personnel will answer or return your call.

DOCTOR'S NOTEBOOK

Trustees' Minutes September 16, 1979

A regular meeting of the Board of Trustees was held on Sunday, September 16, 1979, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

AMA Second Invitational Conference for Physician Negotiators . . . Received a report from Doctors Alessi, Goracci, and Watson on the AMA Conference for Physician Negotiators (September 7-8) which emphasized negotiations with HSAs, as handled in Virginia where consultants are hired to report problems to a vanguard committee which in turn works with coordinating committees with the various HSAs. There is no such coordination of HSA activities in New Jersey; Dr. Alessi felt the concept of the Virginia plan should be studied. Implementation would incur considerable expense to MSNJ.

. . . Referred the subject of HSA coordination to the Executive Committee for study and recommendation.

Diagnostic Related Group (DRG) Project and S-446 . . . Heard comments from Mr. Jack Owen, President of the New Jersey Hospital Association, concerning NJHA's position on the DRG Project and S-446. Implementation of the rate setting mandated by S-446 (involving 26 hospitals, 9 of whom volunteered; 17 were drafted by the Commissioner of Health) has been delayed several times. Target date is now January 1, 1980. Reflecting concern over problems it feels should be corrected before the regulation is implemented, NJHA has prepared a booklet entitled "The DRG Maze," and copies will be supplied to Board members. A hearing will be held September 19 and NJHA will take the position that the regulations formulated by the New Jersey Department of Health are in violation of the original intent of the legislation and should be

reviewed by the legislative oversight committee.

. . . Agreed to refer the DRG project and related legislation to the Commissioner's Medical Advisory Committee for study and recommendations, recognizing the potential impact of this issue on the practice of medicine.

Task Force To Consider Drug and Medication Interactions and Toxicities . . . Expressed appreciation to Stanley S. Bergen, Jr., M.D., President of the College of Medicine and Dentistry of New Jersey, for assisting in the organization of this committee. Dr. Bergen will seek funds for developing a program from the Robert Wood Johnson Foundation.

Conference on Continuing Medical Education . . . Designated Arthur Bernstein, M.D., and Mr. Martin E. Johnson, MSNJ Director of Public Affairs and Medical Education, to represent the Society at the Seventh Annual Conference on Continuing Medical Education for State Medical Association and Specialty Societies, to be held October 18-19 in Chicago.

Council of Medical Specialty Societies . . . Appointed Arthur E. Bernstein, M.D., and Mr. Martin E. Johnson, official representatives of MSNJ at the January 18-19 meeting of the Council of Medical Specialty Societies in Phoenix, Arizona.

MSNJ's Financial Structure and Dues System . . . Accepted advice from the auditors that an internal accounting control system should be flexible, and not detailed in the Bylaws, and that the dues year and fiscal year should not coincide. The auditors' suggestions will be referred to the Committee on Revision of Constitution and Bylaws for use in preparing necessary Bylaws' changes. The Committee on Finance and Budget will be supplied with necessary data to facilitate preparation of material to be presented at the Special Session of the House of Delegates on November 18.

MSNJ's Special Accounts . . . Accepted the auditors' recommendation to merge professional liability monies with general funds, and have the Department of Liability Control become a regular budgetary item. A gradual transition will negate any significant dues impact. This same concept will be applied to the Medical Student Loan Fund.

MSNJ's Banking Services . . . Empowered the executive staff to make changes in the Society's banking services to reflect a better financial return.

Fall Conference of Presidents and Presidents-Elect . . . Approved October 18 as the date for the Fall Conference of Presidents and Presidents-Elect. Subjects to be considered at the Special Session of the House of Delegates (November 18) will be discussed, and those attending can disseminate the information to their respective county members and Delegates..

Meeting of the Board of Trustees . . . Voted to hold a meeting of the Board of Trustees on Sunday, November 11, to discuss the reaction of the county societies to the issues to be considered at the Special Session of the House of Delegates on Sunday, November 18, and to reinforce the Board's position as advocates of the Society's position.

Special Session of the House of Delegates . . . Made official the date of Sunday, November 18, for the meeting of the Special Session of the House of Delegates at MSNJ's headquarters in Lawrenceville.

MSNJ's Student Association . . . Received a report from the MSNJ Student Association which noted that current membership is 254, and that a final report on budget, membership, and services to student members will be included in its October report.

Mailgram Action Bank . . . Approved the following recommendation from the Council on Public Relations:

That the Board of Trustees endorse the Mailgram Action Bank and authorize the solicitation of the MSNJ membership for members who will voluntarily participate in the program.

Note: In May 1979 the Board referred this matter to the Council on Public Relations for study and a report to the Board. It concerns a program by the Washington office of the AMA to generate volume mailings by physicians to legislators via pre-stored computer tapes—all on a voluntary basis.

Annual Meeting . . . Approved the following recommendations concerning the 214th Annual Meeting to be held May 3-6, 1980: (changed to May 10-13)

1. In order to defray costs, scientific and informational exhibits should be eliminated in favor of commercial exhibits, with the understanding that if all booths are not sold, they will be offered to scientific and/or informational exhibitors. *Consideration will be given to the need for space for student recruiting.* (Italics indicate Board amendments.)

Note: Space for 57 exhibits will be available at Bally's Park Place. In the past, scientific and informational exhibits were presented without charge to the exhibitors. In 1979 these exhibits cost MSNJ nearly \$2,000.

2. That the cost of commercial exhibits be raised to \$450 and \$500 for inside and corner booths, respectively

3. That the Motion Picture Theatre be eliminated at the 1980 Annual Meeting.

Note: Attendance at the Motion Picture Theatre has decreased steadily, while operating costs have increased.

Freehold Area Hospital Staff Litigation . . . Reiterated, upon receipt of the following communications, the Board's contention that the medical staff of a hospital has a right to elect its officers:

1. Copy of letter to Freehold Area Hospital's Board of Trustees from the President of the Monmouth County Medical Society, stating that Doctor Robbins deserves a hearing regarding the denial of the position to which he was elected, and if the reasons for denying him the position are not valid, the Hospital is requested to install him in the elected position.

2. Report from Doctor DeSpirito concerning meetings held with Doctor Robbins and with the President and President-Elect of Monmouth County, Doctors L. Glenn Barkalow and George M. Massell, respectively, (Dr. Barkalow

is also Chief of Staff at Freehold Area Hospital) which elicited the following information:

a. Election of Doctor Robbins had followed established procedures, yet his name was rejected by the Hospital's Joint Conference Committee with no explanation. Hospital Bylaws entitle members of the medical/dental staff to a hearing when their status is adversely affected—yet no hearing was held. Dr. DeSpirito indicated that he and Doctors Barkalow and Massell were agreed that Doctor Robbins should be supported in his litigation financially, and by any other means at MSNJ's disposal. Several members of the Hospital's Board of Trustees indicate that misinformation colored the original decision, and they now would install Doctor Robbins as Assistant Chief of Staff. Doctor DeSpirito indicated that costly and lengthy legal proceedings might be avoided if the Board of Governors at Freehold Area Hospital were apprised of MSNJ's support of Doctor Robbins. MSNJ's Executive Staff was authorized to initiate appropriate steps to accomplish the desired result.

Multiphasic Screening Program . . . Requested the Executive Director to explore and report to the Board, concerning the legal and moral responsibilities of physicians multi-phasic screening programs conducted by community service organizations and/or commercial enterprises. MSNJ had requested revisions to the regulations adopted by the State Board of Medical Examiners whereby test results would be sent only to the patient, never to the physician named by the patient. The State Board of Medical Examiners expressed reluctance to change the ruling, stating that the patient might neglect to visit a physician for treatment even when a serious condition exists. Physicians questioned their legal and moral obligations when test results are received on individuals who are not their patients.

Warren County Medical Society Resolution on AMA Membership . . . Approved the following resolution from the Warren County Medical Society:

Whereas, the 1979 House of Delegates appeared sympathetic to the concept of increased voluntary AMA membership; and

Whereas, increased membership would promote greater strength and demonstrate unity; now therefore be it

RESOLVED, that MSNJ, through its component county societies, obtain a list of some

interested members of the staff of each of New Jersey's hospitals willing to increase AMA membership on each hospital staff; and be it further

RESOLVED, that MSNJ, with the help of these "volunteers," provide its House of Delegates with a detailed AMA membership progress report at each meeting until the House decides this volunteer group is no longer needed.

AMA Ad Hoc Committee on Principles of Medical Ethics . . . Received the interim and final reports of the AMA Ad Hoc Committee on the Principles of Medical Ethics, postponing discussion until the next meeting of the Board of Trustees, on the assumption that the reports will be included in material to be discussed at the May 1980 meeting of the House of Delegates.

Foundation of the College of Medicine and Dentistry of New Jersey . . . Agreed that the current representative of MSNJ serving as a trustee of CMDNJ's Foundation, Arthur Bernstein, M.D., be proposed for the 1979-1980 term.

Orthopedic Appliances . . . Authorized the Executive Director to address a communication to the Medicaid Division supporting Bernard A. Rineberg, M.D., and his treatment of Medicaid patients. Dr. Rineberg is an orthopedic surgeon who issues medical appliances from his own stock to his Medicaid patients at prices lower than those of approved appliance dispensers. Medicaid will not reimburse him for these appliances; nor will they issue a license listing him as a dispenser of medical devices. A hearing was held, determining his competency to dispense devices at prices lower than those of approved appliance dispensers, but in the interest of the integrity of the program, his application was denied. As an alternative it was suggested that Doctor Rineberg supply the apparatus to his patient, give the patient a prescription for the device to be obtained from a local dispenser, then have the patient bring that [second] device to Doctor Rineberg. Unhappy with this suggestion, Doctor Rineberg appealed to MSNJ for support.

State Board of Medical Examiners' Hearing Mechanism . . . Heard remarks by Charles Harris, M.D., concerning his appearance before the State Board of Medical Examiners. Doctor Harris felt that his constitutional rights were violated and urged the Board of Trustees not to permit interrogation by the Attorney General's staff at preliminary

hearings, and to make it possible for all parties involved in a case to be present when a hearing is held. The Executive Director pointed out that the hearing mechanism employed by the State Board complies with New Jersey Statutes and State and Federal Constitutions, and that the Attorney General is legal counsel for all state agencies. Doctor Harris appealed to the Society to become interested in preserving physicians' freedom.

Mr. Maressa outlined the procedure: the Attorney General, acting as the administrative/argumentative arm of the State Board of Medical Examiners, presents the case, using interrogatory techniques with the individuals involved; recommended decisions then are made by the committee of doctors chairing the meeting, or an administrative law judge. Upon reaching the State Board level, the Attorney General prepares and argues the case; the Board makes findings and renders a decision.

... Authorized a seminar on October 10 on medical licensure and regulation. The Executive Committee will make recommendations to the House of Delegates concerning the appropriate position to be assumed by MSNJ and methods for articulation and implementation—to be considered at the Fall Session of the House of Delegates on November 18.

CMDNJ Notes*

Stanley S. Bergen, Jr., M.D.
President

Continuing a growing trend that began with its inception nearly a decade ago, the College again has reached a record high in enrollment this school year. A total of 1,714 students are enrolled at CMDNJ's six schools on three campuses, representing an increase of 160 full-time students pursuing degrees in medicine, dentistry and the life sciences.

Since 1970, new teaching facilities, additional educational programs and expansion of affiliations with hospitals throughout the State have allowed the

College to triple its enrollment. This year's boom, however, does reflect a number of "firsts" for CMDNJ.

At the CMDNJ-Rutgers Medical School, Piscataway, enrollment increased from 392 last year to a total of 416. For the first time since 1974, when the full four-year school graduated its first class, CMDNJ-Rutgers Medical School was able to retain its entire third-year class.

In past years, lack of clinical facilities had forced a portion of students completing their basic science studies to go out of New Jersey to complete their degree training. However, with transition to Middlesex General Hospital, New Brunswick, as its core teaching facility well underway, the school this year was able to open up places for its third-year class for all 108 of last year's sophomores.

In Newark, the CMDNJ-New Jersey Medical School accepted 170 first-year students, the largest class in its history. This year's total enrollment at the school is 590. Entering class size had been set at 110 until two years ago, when the school moved into its new Basic Sciences Building. Freshmen entering the class of 1978-79 numbered 140.

Also in Newark, total registry at the CMDNJ-New Jersey Dental School remained stable this year at 258, despite expansion in recent years to its new facilities. With the dental school currently completing transition from a three-year program to the four-year course of study, there is no fourth-year class at the school this term.

The CMDNJ-New Jersey School of Osteopathic Medicine, the College's newest unit, enrolled its third class this year, bringing its total student body to 81. The school's inaugural class of 24 students, now in their third year, began clinical studies at the John F. Kennedy Memorial Hospital in Stratford, the core teaching facility for the osteopathic program. The D.O. candidates take their basic science studies at the CMDNJ-Rutgers Medical School campus in Piscataway, and beginning this year, clinical studies are conducted at hospitals in South Jersey.

Increases in enrollment, though more modest in scale, also are recorded at the College's two other units, both in Newark. The CMDNJ-Graduate School of Biomedical Sciences, which offers M.S. and Ph.D. degrees in the life sciences, currently has a total of 110 degree candidates, as compared with 105 last year. The CMDNJ-School of Allied Health Professions, which provides certificate

courses in specialties such as dental assisting, nurse midwifery, physical therapy and physician assisting, has a full-time register of 259 students, 11 more than last year, with an additional 120 students in part-time programs.

Continuing education programs at CMDNJ range from major three- and four-day symposia to day-long events with lectures and workshops, mini-residencies, and self instruction materials that provide study opportunities at home or office. All programs carry varying amounts of American Medical Association Category I credits. A total of 150 credits are required for the AMA Physicians' Recognition Award as well as for membership in the Medical Society of New Jersey.

Robert R. Moutrie, Ph.D., former executive director of continuing education at the University of Nebraska Medical Center, Omaha, has been serving as CMDNJ's assistant vice president for continuing education since last February. Dr. Moutrie is responsible for statewide development and coordination of continuing education program on all of the College's campuses.

Since CMDNJ's mandate is statewide, the responsibility of Dr. Moutrie is considerable, demanding a work schedule that takes him throughout the state. He has traveled many miles between his base of operations at the Newark campus, and an office in Piscataway, to all points north and south to lay the foundation for programs. As a representative of the state's major health-care provider and health professions educator, he works with the medical and dental societies, allied health associations, hospitals and the Academy of Medicine in the co-sponsorship of programs, many of which are held on the CMDNJ campuses.

Dr. Moutrie plans to include the development of sophisticated systems, surveys, statistics and patient care audits to help point up the needs throughout the State to which the College's continuing education program can serve as part of an answer.

Last year, more than 6,000 physicians, dentists, nurses and others participated in some 90 CMDNJ programs. Attendance ranged from as few as eight or nine physicians in mini-residencies to study new techniques in family-centered therapy and emergency medicine, to the first annual Edward Waters gynecology conference, where several hundred participants attended lectures, workshops and seminars conducted by 45 experts from throughout the nation.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

One of your Foundation's functions is to act as the administrative arm of the New Jersey Statewide Professional Standards Review Council. This is, in many ways, a natural outgrowth of our earlier work as the statewide support center for the developing PSROs of our State. Recently, the Health Care Financing Administration (DHEW) authorized the continuation of this work through September 1980.

The Council has multiple tasks to perform in relation to PSRO activities. Not the least of these is to act as part of the appeals mechanism. Disagreements arising from PSRO review decisions are referred to the Council by the PSRO involved, and they are reviewed by members of the Council's Appeals Committee. Confidentiality is maintained by the removal of all identifiers. This is part of the professional peer review which is the key part of the PSRO law.

As another example, a committee of the Council has been working with the PSROs and the New Jersey State Department of Health, to investigate the relationships between PSROs and the Diagnosis-Related Group (DRG) project. PSROs and the Council are particularly concerned about the quality assurance aspects of DRG. The prospective rate-setting program for New Jersey hospitals is expected to start in January. While the New Jersey Foundation for Health Care Evaluation, like the Medical Society of New Jersey, is reserving judgment on the usefulness and validity of the DRG information experiment, we feel that physician input is essential.

AMA/ERF Program

Medical-student loans guaranteed by the AMA Education and Research Foundation are important in themselves—and also for a reason that goes beyond money. This reason is that they demonstrate—in clear, bottom-line terms—that our AMA federation is interested in nurturing tomorrow's physicians.

Since the program's inception in 1962, some 75,000 loans totaling over \$90 million have been guaranteed. Lately, however, the program's resources have been severely pinched. The demand for

loans has been mounting—to a great extent because federal and other sources of financial assistance for medical education have been drying up while the educational expenses continue to escalate.

Last year more than 4,000 students and physicians-in-training borrowed through the ERF program. This year there can be no more than 2,000. It would be a sad day indeed if the program were to languish for lack of sufficient resources to meet the loan demand. In the words of AMA Executive Vice President James H. Sammons, M.D.:

"The program of aid dramatically affirms medicine's confidence in, and unselfish support for, the future of health care in America. The physician contributors and their spouses of the Auxiliary, whose dedicated efforts and generous gifts over the years have provided the resources and energy that make the program live, merit special recognition."

Just a little extra effort from medical families and from all of the state and county societies would do much to proclaim that confidence in health care's future.

Toll-Free Reporting of Drug and Device Problems

Health care professionals now can dial a toll-free telephone number to report problems they've experienced with drugs, medical devices and *in vitro* diagnostic products. The number is 800-638-6725 (in Maryland, call collect (301) 881-0256).

The Food and Drug Administration encourages health professionals to report:

- hazardous or potentially hazardous products;
- product mislabeling or improper labeling;
- incomplete or confusing instructions;
- erroneous information;
- designs that encourage human error;
- performance failures;
- non-sterile products;
- packaging errors;
- defective components;
- quality control problems; and
- any other situation that could affect the safety and efficacy of a product.

These problem reports help the FDA determine when a product poses a signif-

icant potential hazard to health, sometimes necessitating a recall. The information also is used to detect recurring or widespread problems and to search out deficiencies useful in developing profiles and trends of manufacturer and/or product problems that might suggest needed amendment of performance or good manufacturing standards.

The U.S. Pharmacopeia operates this program under contract with the FDA's Bureau of Drugs and Medical Devices. Callers should be ready to provide their name, zip code, and phone number, product name, strength, size, lot number and expiration date, if applicable and available, date purchased and source, if known, manufacturer's name and address, labeler's name and address, if different from the manufacturer's, and the problem noted.

Auxiliary Activities May 1978—May 1979

The Medical Society of New Jersey Auxiliary has some outstanding accomplishments to its credit during the Auxiliary year that ended in May. One of the Auxiliary's biggest jobs, whether working on the local, state, or national level, is reaching people. This is the first step toward getting people to swing into action.

Mrs. Douglas A. Hammett, Auxiliary President, used "close encounters" as a visible symbol and guidepost to direct the many activities of the Auxiliary. Close encounters, those one-to-one contacts we have with other human beings, are epitomized by the whole idea of health care and service to the community. Four mini-rallies were held at the start of the Auxiliary year for county Presidents and county committee chairmen to discuss possible programs to achieve close encounters of the very best kind.

County auxiliary presidents were given a 350-page book of guidelines, planned and developed by Mrs. Hammett so everyone could work toward specific, agreed-upon goals. The Guidelines were printed at no cost to the Auxiliary through the generosity of Bell Laboratories.

Mrs. Hammett followed up by visiting every County Auxiliary in all 21 counties and conferring with each president. In addition, she attended several meetings

of the Medical Society's Board of Trustees to open lines of communication about Auxiliary activities.

There were many accomplishments during the year; some of the most important ones are listed below.

*Through the efforts of the Auxiliary, a booklet on emergency first aid procedures titled "The Survival Guide" will soon be bound into every New Jersey Bell telephone directory.

*A "Close Encounter with Our Legislators" was held on May 3rd in Trenton. This was a cooperative effort with Dr. Frank Watson, the Medical Society's JEMPAC Chairman.

*During this term, over \$14,000 was raised for the AMA-ERF.

*Parenting, a community educational project (on what being a good parent is all about) was carried out in public libraries in conjunction with the New Jersey Home Economics Association.

*Monies were raised for the Medical Student Loan Fund, always a top priority concern of the Auxiliary.

*Our Community Education projects were some of the most rewarding encounters of all. For example, CPR teaching activities have gathered great momentum. It is the Auxiliary's goal to have at least one member of every family in the community trained in CPR techniques.

*Much work was done in the AMA Immunization Awareness campaign, which involves school poster distribution and special playground hopscotch layouts.

*Other school programs for young children include showings of a motion-picture to take some of the mystery out of what goes on in a hospital.

*Other community service programs include basic first aid, self-breast examinations, eye health screening, automobile safety-belt education, anti-smoking campaign, and the Heimlich Maneuver. In the case of the latter activity, community-minded dairies have printed the Heimlich Maneuver on their milk cartons, as well as immunization reminders.

*Membership expansion was a program that was stressed on an all-out basis. Mrs. Frank Romano, State Membership Chairman, and Mrs. Hammett worked on a new membership brochure, which was distributed throughout the Auxiliary and the Medical Society. An enlarged membership will give the Auxiliary the means to make more and greater close encounters to improve and expand the health needs of the citizens of New Jersey.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

CARDIOLOGY—Joseph Chathampadathil, M.D., 3910 Powelton Avenue, Apt. 505, Philadelphia, PA 19104. Trivandrum (India) 1968. Also general internal medicine. Board certified (IM). Institutional, solo, or group. Available July 1980.

George Demidowich, M.D., 501 Stuyvesant Avenue, Irvington 07111. New York Medical College 1975. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1980.

Sudhir Amaram, M.D., 1310 Pennsylvania Avenue, Apt. 12-E, Brooklyn, NY 11239. Osmania (India) 1973. Also general internal medicine. Board certified (IM). Partnership, group, solo. Available July 1980.

CARDIOVASCULAR DISEASES—Lee Merrill Krause, D.O., 239 Brydolt Road, Philadelphia PA 19151. Phila. College of Osteopathic Medicine 1975. Also general internal medicine. Board eligible (IM). Solo, single or multi-specialty group, partnership. Available July 1980.

DERMATOLOGY—David Herschthal, M.D., 6924 SW 114th Place, Miami, FL 33173. New York Medical 1976. Solo, multi-specialty group, partnership. Available June 1980.

FAMILY PRACTICE—Frazil Kideys, M.D., 17 Agate Street, East Brunswick 08816. Istanbul 1953. Board eligible. Partnership or solo. Available.

Eric N. Kruger, M.D., Hunter Hills, G-4, Flemington 08822. Jefferson. Group, partnership, solo. Available July 1980.

GASTROENTEROLOGY—Robert D. Lafsky, M.D., 3605 Weightman Street, Philadelphia, PA 19129. University of Pennsylvania 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

Norman Zitomer, M.D., 1113 Rodman Street, Philadelphia, PA 19147. SUNY-Downstate 1975. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1980.

GENERAL PRACTICE—Bruce M. W. Burns, M.D., 930 Steib Terrace, Union 07083. Michoacan (Mexico) 1977. Subspecialty, psychiatry. Any type practice. Available.

Thomas W. Lister, M.D., Route 3, Box 417 CD, Cameron, TX 76520. University of Texas 1968. Group, partnership, industrial, student health. Available.

GYNECOLOGY—Arthur G. Murphy, M.D., 1491 Janet Place, Englewood, FL

33533. Cornell 1940. School health, institutional, administrative. Available.

INTERNAL MEDICINE—Abdul Majeed, M.D., 11-01 Kennedy Boulevard, North Bergen 07047. Dow (Pakistan) 1975. Board eligible. Institutional, solo, partnership. Available.

Miguel A. Maseda, M.D., 105 Fifth Avenue, Bradley Beach 07720. Madrid 1977. Single-specialty group, partnership, solo. Available July 1980.

Robert B. Liberman, M.D., 51 Harnden Avenue, Watertown, MA 02172. CMDNJ 1977. Single or multi-specialty group, partnership, research, institution, l, solo. Available July 1980.

Sriram Sudarshan, M.D., 1100 Parsippany Boulevard, Apt. 263, Parsippany 07054. Gandhi Medical College (India) 1968. Subspecialty, cardiology. Board certified. Solo or partnership. Available.

James W. Baird, M.D., 1500 Locust Street, Apt. 3312. Philadelphia, PA 19102. Johns Hopkins 1968. Subspecialty, physical medicine and rehabilitation. Board certified. Multi-specialty group, partnership, solo. Available August 1980.

David A. Stein, M.D., 3811 Bluebonnet Boulevard, Houston, TX 77025. New York Medical 1975. Subspecialty, pulmonary diseases. Board certified. Partnership, institutional, multi-specialty group. Available October 1980.

Bennett H. Bruckner, M.D., 192 Garth Road, Apt. 6-M, Scarsdale, New York 10583. Emory 1973. Board eligible. Group, partnership, solo. Available.

Barton E. Cohen, M.D., 166 East 34th Street, Apt. 10-G, New York, NY 10016. NYU 1975. Subspecialty, cardiology. Board certified. Group, partnership. Available July 1980.

Jam Stanley Glowacki, M.D., 29 Maple Avenue, Fair Haven 07701. Jefferson 1977. Board eligible. Solo, partnership, group. Available July 1980.

Miguel A. Maseda, M.D., 106 Fifth Avenue, Bradley Beach 07720. Madrid 1977. Board eligible. Solo, group, partnership. Available July 1980.

Iradj Shairm, M.D., 89 Central Avenue, Morrisville, PA 19067. Iran 1970. Board certified. Partnership, group. Available.

Richard J. Fastiggi, M.D., 14 W. Cold Spring Lane, Apt. 302, Baltimore, MD 21210. CMDNJ 1977. Board eligible. Emergency room. Available July 1980.

Patricia Costanzo, M.D., 12 Tory Court, Colts Neck 07722. CMDNJ 1974. Subspecialty, pulmonary medicine. Board certified. Any type practice. Available July 1980.

NEPHROLOGY—Dariush Arfaania, M.D., 1718 E. Broadway, Apt. D, Columbia, MO 65201. Pahlavi (Iran) 1973. Also general internal medicine. Board eligible (IM). Institutional, single or multi-specialty group. Available January 1980.

NEUROLOGY—Ahmad Y. Haffar, M.D., 1905 Faith Place, Gretna, LA 70053. Damascus (Syria). Solo, group, or partnership. Available.

Seung K. Rho, M.D., 1700 Seaspray

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Court, Apt. 1233, Houston, TX 77008.
Seoul (Korea) 1970. Board eligible. Solo or
group. Available January 1980.

OBSTETRICS/GYNECOLOGY—Jose S.
Kua, M.D., 9503 Peartree Lane, Cypress,
CA 90630. Santo Tomas (Philippines)
1971. Subspecialty, general practice. Board
certified. Solo, partnership, single-specialty
group. Available January 1980.

Yacov Tal, M.D., 2356 Mickle Avenue,
Bronx, NY 10469. Tel Aviv (Israel) 1976.
Partnership, single or multi-specialty
group. Available July 1980.

Alejandro F. Aguilar, M.D., 602 Patterson
Road, Bethel Park, PA 15102. San Agustin
(Peru) 1969. Board eligible. Multi-specialty
group, partnership, solo. Available Janu-
ary 1980.

Zuhair M. El Kalaadui, M.D., 100 Boteler
St. Apt. 1106, Ottawa, Canada K1N 8Y1.
Ain Shams (Egypt) 1972. Board
eligible. Single or multi-specialty group,
partnership. Available January 1980.

Michael T. Kicenuik, M.D., 49 Crescent
Road, Livingston 07039. CMDNJ 1976.
Group, partnership, solo, or industrial.
Available July 1980.

Pabilto S. Luz, M.D., 3506 Camellia Cir-
cle, Columbus, OH 39701. Far Eastern
(Philippines) 1962. Board eligible. Partner-
ship, single-specialty group, solo. Available
March 1980.

Theodore Kohn, M.D., 6441 N. Francisco
Avenue, Chicago, IL 60645. Mexico 1962.
Board eligible. Solo, partnership, group.
Available.

Khalid Parwez, M.D., 420 Stockholm
Street, Apt. C-9, Brooklyn, New York
11237. Nishtar (Pakistan) 1971. Board
eligible. Group, partnership, association.
Available July 1980.

Robert A. Stern, M.D., 7 Balint Drive,
Apt. 128, Yonkers, NY 10710. New York
Medical College 1976. Board eligible.
Group. Available July 1980.

Sung Ho Lee, M.D., 400 Elruth Court,
Apt. 141, Girard, OH 44420. Seoul (Ko-
rea). Solo, group, or associate. Available
July 1980.

Robert J. Lipari, M.D., Jewish Hospital
and Medical Center, 555 Prospect Place,
Brooklyn, New York. Bologna (Italy)
1975. Board eligible. Group or partnership
—flexible. Available July 1980.

Woo-Gill Jeong, M.D., 203 Churchill Hub-
bard Road, #4, Youngstown, OH 44505.
Chonnam (Korea). Board eligible. Group
or partnership. Available July 1980.

Dhanlakshmi Venkataraman, M.D., Kens-
ington Arms, Apt. 22-B, Hightstown
08520. Jabalpur (India) 1969. Board
eligible. Partnership, hospital-based,
group, solo. Available June 1980.

ONCOLOGY—Stanley Ostrow, M.D., 9
Wychwood Court, Balitmore, MD 21209.
SUNY-Downstate 1974. Also general in-
ternal medicine. Board certified (IM). Sin-
gle or multi-specialty group, partnership.
Available June 1980.

OPHTHALMOLOGY—Ira Goodman,
M.D., 643 West Barry, Chicago, IL 60657.
Loyola 1974. Board certified. All types
practice. Available.

Steven N. Cohen, M.D., 1355 Palos Verdes Drive, San Matco, CA 94403. Cornell 1974. Board eligible. Solo, partnership, single-specialty group. Available.

Jerrold E. Ziperstein, M.D., 1900 Lyttonsville Road, Apt. 1314, Silver Spring, MD 20910. Montpellier (France) 1973. Board eligible. Partnership, single-specialty group, solo. Available.

Gregory I. Goldman, M.D., Texas Tech. University School of Medicine, Dept. of Ophthalmology, Lubbock, TX 79409. Far Eastern (Philippines) 1976. Solo, partnership, single or multi-specialty group. Available July 1980.

OTOLARYNGOLOGY—Howard Taylor, M.D., 1560 Chicago, IL 60610. Columbia 1976. Board eligible. Partnership, solo, group, or academic affiliation. Available July 1980.

OTORHINOLARYNGOLOGY—Jeffrey Adelgass, M.D., 12 East 86th Street, New York, NY 10028. Board eligible. Group, partnership, solo. Available July 1980.

PATHOLOGY—N. Mirzabeigi, M.D., 603-B South Trenton Avenue, Pittsburgh, PA 15221. Teheran (Iran) 1967. Board certified (anatomical and clinical pathology). Associate or assistant. Available.

Singh C. Mohinder, M.D., 470 Gale Boulevard, Melvindale, MI 48122. Maulana (India) 1970. Partnership, multi-specialty group, research. Available January 1980.

PEDIATRICS—Martin M. Fisher, M.D., Division of Adolescent Medicine, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042. Einstein 1975. Subspecialty, adolescent medicine. Board eligible. Group, partnership, institutional. Available July 1980.

Nelly A. Marklein, M.D., 88-34 Rutledge Avenue, Glendale, NY 11227. Santo Tomas (Philippines) 1963. Board certified. Multi-specialty group, solo, public health. Available January 1980.

Anju K. Khanijou, M.D., 260-14 74th Avenue, Glen Oaks, Queens, NY 11004. All-India 1973. Board eligible. Single or multi-specialty group, institutional. Available January 1980.

Bernardita T. Gabriel, M.D., 52-15 Seabury Street, Elmhurst, NY 11373. Santo Tomas (Philippines) 1972. Board eligible. Partnership, single or multi-specialty group. Available.

Raksha J. Gajarawala, M.D., 36 Everett Road, Demarest 07627. N.H.L. (India) 1967. Board eligible. Group or partnership. Available.

Asha N. Madia, M.D., 5015 S.W. 9th Street, Apt. #97, Des Moines, IA 50315. Seth G.S. (India) 1970. Board eligible. Clinic practice. Available.

PEDIATRIC HEMATOLOGY/ONCOLOGY—Sudhakar S. Chagavath, M.D., 110-52 63rd Drive, Forest Hills, NY 11375. G.S. Medical College (India) 1971. Board certified (Pediatrics). Any type practice. Available July 1980.

PHYSICAL MEDICINE/REHABILITATION—Jeffrey A. Brustein, M.D., 777

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Pelham Road, Apt. 2-B, New Rochelle, NY 10805. Creighton 1976. Partnership, group, solo. Available July 1980.

PSYCHIATRY—Marc Rothman, M.D., Presidential Apts., Apt. C-822, City Line and Presidential Blvd., Philadelphia, PA 19131. SUNY-Upstate. Board eligible. Group, partnership, hospital. Available July 1980.

Pradeep Rattan, M.D., 1214 West Harrison, Apt. 1214, Chicago, IL 60612. Calcutta (India) 1972. Board eligible. Institutional, single-specialty group, partnership. Available.

PULMONARY MEDICINE—Leonard Sonne, M.D., 191 Beacon Street, Boston, MA 02116. New York Medical 1974. Board certified. Group, partnership, solo. Available July 1980.

Michael Falkowitz, M.D., 245-20 Grand Central Parkway, Bellerose, NY 11426. SUNY-Downstate 1975. Also general internal medicine. Board certified (IM). Group, partnership, or hospital-based setting. Available July 1980.

David L. Kamelhar, M.D., 160 East 27th Street, New York, NY 10016. NYU 1974. Also general internal medicine. Board certified (IM). Group, partnership, or hospital. Available July 1980.

RHEUMATOLOGY—Zahid Husain, M.D., 60 Presidential Plaza, Apt. 1208, Syracuse, NY 13202. Dacca (Pakistan) 1972. Also general internal medicine. Board certified (IM). Partnership, solo, multi-specialty group. Available October 1980.

Christopher J. Lynch, M.D., 130 Stanton Court West, Pittsburgh, PA 15201. Cornell 1975. Also general internal medicine. Board certified (IM). Solo, group, partnership. Available July 1980.

SURGERY, CARDIOVASCULAR—Charles H. Antinori, M.D., 4400 Memorial Drive, Apt. 1019, Houston, TX 77007. Harvard 1973. Special interest, thoracic surgery. Board eligible (general surgery). Single-

specialty group, solo, research. Available July 1980.

Louis T. Kanda, M.D., 12000 Edgewater Drive, Lakewood, OH 44107. George Washington 1970. Special interest, thoracic surgery. Board certified (general surgery). Group, partnership, institutional. Available August 1980.

SURGERY, GENERAL—Rajesh Khanijou, M.D., 260-14 74th Avenue, Glen Oaks, Queens, NY 11004. All India 1973. Board eligible. Single or multi-specialty group, partnership, institutional. Available January 1980.

Raduf B. Korkor, M.D., 7600 Kirby Drive, Apt. 1313, Houston, TX 77030. Damascus (Syria) 1973. Special interest, colon and rectal surgery. Board eligible (general surgery). Single or multi-specialty group, partnership, solo. Available.

Sahibzada A. Ahmed, M.D., 501 Sixth Street, Apt. 3-J, Brooklyn, NY 11215. Dacca (Bangladesh) 1970. Board eligible. Solo, group, Hospital-based. Available July 1980.

F. Wesner Fleurant, M.D., 103 Gail Drive, New Rochelle, NY 10805. Haiti 1959. Special interest, vascular surgery. Board certified. Group, association, partnership, institutional, industrial, solo. Available.

SURGERY, ORTHOPEDIC—Victor Tseng, M.D., 1019 Everett Avenue, Apt. 3, Louisville, KY 40204. SUNY-Downstate 1970. Special interest, hand surgery. Board eligible. Single-specialty group, partnership, solo. Available.

Kaushal K. P. Sinha, M.D., 3513 Cairnbrook Drive, Columbia, SC 29210. Prince of Wales (India) 1966. Board eligible. Solo, partnership, single-specialty group. Available.

Stephen L. Brenner, M.D., 350 East 17th Street, Apt. 17-A, New York, NY 10003. Guadalajara 1974. Single or multi-specialty group, partnership. Available July 1980.

Elliot N. Lang, M.D., 356 Central Avenue, Scarsdale, NY 10583. Temple 1975. Board eligible. Solo, group, partnership. Avail-

able July 1980.

Philip D'Ambrosio, M.D., 4 Maple Drive, Apt. 5-L, Great Neck, NY 11021. Georgetown 1976. Group. Available July 1980.

SURGERY, THORACIC—Louis T. Kanda, M.D., 12000 Edgewater Drive, Lakewood, OH 44107. George Washington 1970. Board certified (general surgery). Group, partnership, institutional. Available August 1980.

SURGERY, UROLOGICAL—Fredy E. Delacruz, M.D., Box O, Balboa Heights, Balboa, Canal Zone. Guadalajara 1972. Board eligible. Partnership, solo, institutional, multi- or single-specialty group. Available.

Philip L. Miller, M.D., 333 East 30th Street, Apt. 18-B, New York, NY 10016. Chicago 1973. Partnership, single or multi-specialty group. Available July 1980.

Vodur C. Reddy, M.D., 1571 Main Street, Apt. 26, West Warwick, RI 02893. Guntur (India) 1961. Partnership, single or multi-specialty group. Available July 1980.

Richard Kroll, M.D., 16 Pick Avenue, Fort Leavenworth, KS 66027. Albany, New York 1972. Board eligible. Partnership or single-specialty group. Available July 1980.

UROLOGY—Yih-Wen Lai, M.D., 4219 Oakcrest Drive, Lorain, OH 44053. Taipei (Taiwan) 1964. Board eligible. Solo, group, partnership. Available.

Talal Samhan, M.D., Good Samaritan Hospital, Cincinnati, OH 45220. Mosul (Iraq) 1972. Partnership, institutional, group, solo. Available July 1980.

Eugene De Salvo, M.D., 400 Rutherford Boulevard, Clifton 07014. CMDNJ 1975. Solo, partnership, group. Available July 1980.

Daniel P. Wiener, M.D., 3226 Steuben Avenue, Bronx, NY 10467. Einstein 1974. Board eligible. Group, solo, partnership, academic P/T. Available July 1980.

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Phenylpropanolamine

August 22, 1979

Dear Editor:

We represent Alleghany Pharmacal Corporation, owner of United States Trademark Registration No. 650, 021 for "P.P.A." in International Class 5, former U.S. Class 18. This exclusive ownership entitles our client to the sole right to use this mark to indicate the presence of phenylpropanolamine hydrochloride as an ingredient in an appetite depressant in the treatment of obesity.

It has been brought to our attention that an article "Convulsive Seizures Due to Phenylpropanolamine," was published in *The Journal of the Medical Society of New Jersey*, Vol. 76-Number 9-August 1979. Although reporting on phenylpropanolamine, the article likewise contains references to our client's trademark "P.P.A."

Accordingly, any reference to "P.P.A." must necessarily designate ownership of the mark in order to prevent dilution under various Federal and State laws. As you should be aware, other manufacturers and distributors of non-prescription dietary drugs cannot make reference to either the actual product or any of its ingredients as "P.P.A." without disclosing that it is a registered trademark of Alleghany Pharmacal Corporation.

Alleghany has made widespread and continued use of this well-known mark in connection with products such as Permathene-12, Sip 'n Slender, and Hungrex. Much like the cases of "Band Aid," "Cellophane" and "Formica," for

example, this popular trademark also requires diligent protection against infringement as well as conversion to a generic name through public use of the mark as a "common descriptive name." Recognized as a valuable property right, our client has vigorously protected "P.P.A." from both dilution and infringement. We would certainly appreciate your cooperation in the furtherance of this objective.

Due to the diluting nature *The Journal's* use of "P.P.A.," though non-infringing, protection of the mark would be secured with the publication of an adequate correction notice as soon as possible. We welcome your response to this request and believe that it is both reasonable and appropriate.

We thank you in advance for your cooperation.

Friend, Perles, Dorfman & Kleefeld
(signed) Jerold W. Dorfman

August 27, 1979

Dear Dr. Krosnick:

In my recent article, "Convulsive Seizures Due to Phenylpropanolamine," Vol. 76-Number 9-August 1979, reference was made to phenylpropanolamine (PPA). I was not aware that "P.P.A." is a registered trademark of Alleghany Pharmacal Corporation.

My usage of (PPA) is mainly to indicate an abbreviation of phenylpropanolamine, a generic drug, as

is customarily done in various medical journals. I did not intend to use my (PPA) as a trademark of any corporation, but as I indicated.

(signed) P.D. Deocampo, M.D.

Editor's Note: "P.P.A." is a registered trademark of the Alleghany Pharmacal Corporation.

Billing Techniques

September 20, 1979

Dear Sir:

I believe that physicians should adopt the billing techniques of lawyers. As a subscriber to the interesting monthly magazine *The American Lawyer*, I have learned that lawyers bill clients on an hourly basis including telephone calls (billed at a minimum of 15 minutes no matter if it is a 15-second call), reading and research on the case, and of course, talking to clients. I don't see why we can't submit itemized bills for each patient and charge what the lawyers do. This also would end the disparity between the internist who is up all night with a complicated arrhythmia and the surgeon who does an elective hernia. Also, if the people want us to be "their doctor" they should pay us retainers.

Since Governor Byrne and most of the legislators are lawyers, how can they fault us with not participating in Medicaid unless we are compensated as they are?

(signed) Howard J. Berkowitz, M.D.

CME CALENDAR

MEDICINE (includes Family, Internal, and General Medicine and Dermatology)

Dec.

- 4 Diabetes**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)
- 4 Diabetes Mellitus—Today and Tomorrow**
8-10 p.m.—Saddle Brook General Hospital
(Saddle Brook General Hospital and AMNJ)
- 4 Hyperlipidemia**
- 11 Myocardium**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(Greater Paterson General Hospital and AMNJ)
- 4 Indications for Endoscopy**
- 11 Oral Lesions in General Practice**
- 18 Spondyloarthropathy**
8-9 a.m.—Garden State Community Hospital, Marlton
(Garden State Community Hospital and AMNJ)
- 4 Cardiac Arrhythmias**
- 11 Infectious Disease**
- 18 Hypertension Telephone Forum**
9 a.m.—Holy Name Hospital, Teaneck
(Holy Name Hospital)
- 5 Laboratory Interpretations**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)
- 5 Evaluating the Patient with Chest Pain**
- 12 To be announced**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)
- 5 Obesity**
- 12 Medical Lecture Series**
- 19 1-3 p.m.—Christ Hospital, Jersey City**
(Christ Hospital and AMNJ)
- 20 Neonatology**
No time given—Newark Beth Israel Medical Center
(AMNJ)
- 5 Biopsies of Gastrointestinal Tract**
1-5 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 5 Endocrinology Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(Endocrinology Section of AMNJ)
- 5 Endocrinology Series**
11:30 a.m.-1:30 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)

- 5 Medical Lecture Series**
- 12 1-2:30 p.m.—VA Medical Center, Lyons**
(VA Medical Center and AMNJ)
- 26**
- 5 Endocrine Conferences**
- 12 3:30-5 p.m.—Rotates between Newark**
19 Beth Israel Medical Center, College
26 Hospital, Newark and VA Medical
Center, East Orange
(Endocrinology Section of AMNJ)
- 6 Anorexia Nervosa**
- 13 Testicular Carcinoma**
9:30-11 a.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)
- 11 Lecture Series**
8-10 p.m.—Schering Corporation, Kenilworth
(NJ Dermatological Society and AMNJ)
- 11 Gastrointestinal Bleeding**
2 p.m.—Ancora Psychiatric Hospital Hammonton
(AMNJ)
- 11 Hematology**
8:30 p.m.—Fair Lawn Memorial Hospital
(AMNJ)
- 12 Migraine and Its Equivalents**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(Dover General, Riverside, and St. Clare's Hospitals)
- 12 Drug-Induced Diseases**
- 19 Contemporary Treatment of Arthritis**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital)
- 12 Cardiac Rehabilitation**
4-5 p.m.—Kessler Institute, West Orange
(Kessler Institute for Rehabilitation and AMNJ)
- 18 Newer Drugs for Hypertension**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
- 18 Gastrointestinal Bleeding**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)
- 19 Cor Pulmonale**
11:0 a.m.-1 p.m.—VA Medical Center, East Orange
(VA Medical Center and AMNJ)
- 19 Prophylactic Use of Antibiotics**
1-4 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)
- 21 Proper Use of Antibiotics**
12 noon—Freehold Area Hospital
(AMNJ)

Jan.

- 2 Endocrinology Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(Endocrinology Section of AMNJ)
- 2 Endocrinology Series**
11:30 a.m.-1 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)
- 2 Colitis**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)
- 2 Medical Lecture Series**
- 16 1-3 p.m.—Christ Hospital, Jersey City**
23 (Christ Hospital and AMNJ)
30
- 2 Advances in Medicine**
- 9 9:30-11 a.m.—Bergen Pines County**
16 Hospital, Paramus
23 (Bergen Pines County Hospital and
30 AMNJ)
- 2 Growth Hormone in Health and Disease**
- 16 Acute Gastrointestinal Hemorrhage**
- 23 Management of Poisonings**
- 30 Evaluation of Chest Pain**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)
- 2 Endocrine Conferences**
- 9 3:30-5 p.m.—Rotates between Newark**
16 Beth Israel Medical Center, College
23 Hospital, Newark and VA Medical
30 Center, East Orange
(Endocrinology Section of AMNJ)
- 2 Medical Lecture Series**
- 9 1-2:30 p.m.—VA Medical Center, Lyons**
16 (VA Medical Center and AMNJ)
23
30
- 7 Diverticular Disease of the Colon**
- 21 Hemorrhagic Shock**
- 28 Hypertrophic Gastritis**
4:30-5:30 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 8 Dermatological Office Surgery**
8-10 p.m.—Schering Corporation Kenilworth
(New Jersey Dermatology Society)
- 8 Hematology**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)
- 9 Proper Use of Antibiotics**
11:30 a.m.-1 p.m.—Rahway Hospital
(AMNJ)
- 9 Laboratory Interpretations**
1:30 p.m.—John E. Runnells Hospital,

- Berkeley Heights
(*AMNJ*)
- 9 Musculo-Skeletal Pain**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 10 Management of Hypertension**
8-9 p.m.—Garden State Community Hospital, Marlton
(*Burlington Co. Medical Society and AMNJ*)
- 15 Indications for Mini-Heparin**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 16 Pulmonary Tuberculosis in Adults**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 16 Management of Cardiac Arrhythmias**
1-4 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 16 Pulmonary Disease Topic**
No time given—VA Medical Center, East Orange
(*AMNJ*)
- 16 Percutaneous Coronary Artery Dilation**
- 30 Infections in Community Hospitals**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(*Dover General, Riverside and St. Clare's Hospitals and AMNJ*)
- 17 Treatment of Cardiac Arrhythmias**
9:30-11 a.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)
- 17 Cardiac Rehabilitation**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 18 Clinical Immunology**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 21 Immunology in Cancer**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 30 Acute Renal Failure**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)

NEUROLOGY/PSYCHIATRY

Dec.

- 3 Psychotherapy with a Chronic Schizophrenic**
8-10 p.m.—192 Chittenden Rd., Clifton
(*Essex Psychiatric Seminar and AMNJ*)
- 3 Neuroscience Conferences**
- 10 11:30 a.m.-12:30 p.m.—Bergen Pines**
- 17 County Hospital, Paramus**
(*Bergen Pines County Hospital and AMNJ*)
- 4 Psychiatric Case Conferences**
- 11 7:30-9:30 a.m.—Trenton Psychiatric**
- 18 Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 4 Seminar on Law and Psychiatry**
- 11 3:30-5:30 p.m.—Rutgers Law School**
- 18 Newark**
(*Rutgers University Law School and AMNJ*)
- 5 Neurological Problems of Infancy and Childhood**

- 9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital, AAFP and AMNJ*)
- 5 Child Psychiatry Case Conference**
- 12 8:30-10:30 a.m.—Trenton Psychiatric**
- 19 Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 5 Distinguished Speakers Series**
- 19 1:30-3 p.m.—NJ Medical School, Newark**
(*CMDNJ and AMNJ*)
- 5 Psychiatric Lecture Series**
- 12 1-3 p.m.—Ancora Psychiatric Hospital,**
- 19 Hammonton**
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 Psychiatric Lecture Series**
- 13 11 a.m.-12 noon—Greystone Park**
- 20 Psychiatric Hospital**
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 27**
- 6 Case Seminars**
8-10 p.m.—312 Harding Drive, So. Orange
(*Advanced Psychiatric Group and AMNJ*)
- 6 Behavior Therapy**
- 13 Combining ARU and Hypocrites**
- 20 Psychotropic Drug Interactions**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 12 Migraine and Its Equivalents**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(*Dover General, Riverside and St. Clare's Hospitals and AMNJ*)
- 12 Biofeedback in Clinical Practice**
1-4 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 12 Grand Rounds in Psychiatry and**
- 26 Mental Health Science**
1:30-3 p.m.—NJ Medical School, Medical Science Bldg., Newark
(*CMDNJ-NJ Medical School and AMNJ*)
- 13 Obesity and its Treatment**
8-9 p.m.—Mount Holly Center 62 Richmond Ave., Mt. Holly
(*Burlington County Medical Society and AMNJ*)
- 13 What Is Liaison Psychiatry?**
11:30 a.m.-12:30 p.m.—Muhlenberg Hospital, Plainfield
(*Muhlenberg Hospital*)
- 19 Movement Disorders**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)

Jan.

- 2 Child Psychiatry Case Conference**
- 9 8:30-10:30 a.m.—Trenton Psychiatric**
- 16 Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 3 Psychotherapeutic Techniques**
8-10 p.m.—312 Harding, Drive, So. Orange
(*Advanced Psychiatric Study Group and AMNJ*)
- 3 Psychiatric Lecture Series**
- 10 11 a.m.-12 noon—Greystone Park**
- 17 Psychiatric Hospital**
(*Greystone Park Psychiatric Hospital and AMNJ*)

- 7 Lecture Series**
8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminary and AMNJ*)
- 7 Neuroscience Conferences**
- 14 11:30 a.m.-12:30 p.m.—Bergen Pines**
- 21 County Hospital, Paramus**
(*Bergen Pines County Hospital and AMNJ*)
- 28**
- 8 Psychiatric Case Conferences**
- 15 7:30-9:30 a.m.—Trenton Psychiatric**
- 22 Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 29**
- 8 Seminar on Law and Psychiatry**
- 15 3:30-5:30 p.m.—Rutgers Law School,**
- 22 Newark**
(*Rutgers University Law School and AMNJ*)
- 9 Grand Rounds in Psychiatry and Mental**
- 23 Health Science**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 9 Use of Meditation and Hypnosis**
- 16 Behavior Therapy-Inpatient Uses**
- 23 Management of the Problem Drinker**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 10 Psychotherapy Schizophrenia**
- 17 Use of Positron Emission Tomography in Study of Cerebral Metabolism**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 16 Presence of Endogenous Morphinemimetics**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 16 Milieu Therapy**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)
- 22 Hypertension**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 23 Multiple Sclerosis**
4-5 p.m.—Kessler Institute, West Orange
(*Kessler Institute for Rehabilitation and AMNJ*)
- 29 Current Chemotherapy**
2 p.m.—Ancora Psychiatric Hospital
(*AMNJ*)

OBSTETRICS/GYNECOLOGY

Dec.

- 5 Lectures in Ob/Gyn**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 5 Combined Grand Rounds in Ob/Gyn**
- 21 3-5 p.m.—Rotates between College**
- 19 Hospital, Newark Beth Israel,**
- 26 St. Michael's Medical Centers, Newark, St. Joseph's Hospital and Medical Center, Paterson and Jersey City Medical Center**
(*CMDNJ and AMNJ*)
- 6 Grand Rounds in Obstetrics and**
- 13 Gynecology**
- 20 4-5 p.m.—College Hospital, Newark**
- 27**
(*CMDNJ and AMNJ*)

12 *Pregnancy-Induced Hypertension*
8-9 a.m.—Garden State Community
Hospital, Marlton
(*Garden State Community Hospital*
AMNJ)

Jan.
2 **Lectures in Obstetrics/Gynecology**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
2 **Grand Rounds in Ob/Gyn**
9 3-5 p.m.—Rotates between CMDNJ-
16 College Hospital, Newark Beth Israel
23 and St. Michael's Medical Centers,
30 Newark, St. Joseph's Hospital and
Medical Center Paterson, and Jersey
City Medical Center
(*CMDNJ and AMNJ*)
3 **Grand Rounds in Ob/Gyn**
10 4-5 p.m.—College Hospital, Newark
17 (*CMDNJ and AMNJ*)
24
31

PATHOLOGY
Dec.
11 **Pathology Lectures**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
26 **Clinical Pathology Conference**
9:30-11 a.m.—Bergen Pines County
Hospital, Paramus
(*Bergen Pines County Hospital and*
AMNJ)
Jan.
8 **Pathology Lectures**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

PEDIATRICS
4 **Pediatric Respiratory Infections**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
5 **Neurological Problems of Infancy and**
Childhood
9-11 a.m.—Roosevelt Hospital, Menlo
Park
(*Middlesex Hospital, AAFP, and AMNJ*)
17 **The Child with Short Stature**
12 noon-1 p.m.—Mountainside
Hospital, Montclair
(*Mountainside Hospital and AMNJ*)

RADIOLOGY
Dec.
5 **Neuro-Radiology Meeting**
7:45-10:15 p.m.—Morristown Memorial
Hospital
(*Radiological Society of NJ and AMNJ*)

Jan.
9 **Neuro-Radiology Meeting**
7:45-10:15 p.m.—Morristown Memorial
Hospital
(*Radiological Society of NJ and AMNJ*)
16 **Radiotherapy Section Dinner Meeting**
6:30—The Manor, West Orange
(*Radiotherapy Section, AMNJ*)
17 **Topic to be announced**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for*
Northern NJ and AMNJ)

GENERAL SURGERY
Dec.
1 **28th Annual Clinical Meeting**
9-5 p.m.—Rutgers Medical School,
Piscataway
NJ Chapter, American College of
Surgeons and AMNJ
3 **Distinguished Lecture Series in**
10 **Surgery and Grand Rounds**
17 4:30-5:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
4 **Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
4 **Tumor Conferences**
11 11 a.m.-12 noon—Morristown
18 Memorial Hospital
(*Morristown Memorial Hospital and*
AMNJ)
13 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital,
Kearny
(*West Hudson Hospital and AMNJ*)
21 **Tumor Conference**
12 noon-1 p.m.—Elizabeth General
Hospital
(*Elizabeth General Hospital and AMNJ*)
Jan.
8 **Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)

8 **Tumor Conferences**
15 11 a.m.-12 noon—Morristown
22 Memorial Hospital
29 (*Morristown Memorial Hospital and*
AMNJ)
18 **Tumor Conference**
12 noon-1 p.m.—Elizabeth General
Hospital
(*Elizabeth General Hospital and AMNJ*)
22 **Selecting Patients for Carotid Surgery**
8 p.m.—Warren Hospital, Phillipsburg
(*AMNJ*)

**SURGICAL SPECIALTIES (includes ENT,
Neurosurgery, Ophthalmology, Orthopedic,
Plastic, and Vascular Surgery)**
Dec.
13 **Common Athletic Injuries**
5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)
18 **Vascular Clamping Problems and**
Solutions
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

Jan.
9 **Bioengineering and Orthopedic Surgery**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)

MISCELLANEOUS
Dec.
4 **Governmental Regulations on Practice**
of Occupational Medicine
1 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ*)
6 **Developmental Biology**
13 4-6 p.m.—Institute for Medical
Research, Copewood St., Camden
(*Institute for Medical Research and*
AMNJ)
13 **Common Athletic Injuries**
5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)

Jan.
10 **Developmental Biology**
17 4-6 p.m.—Institute for Medical
24 Research, Copewood St., Camden
31 (*Institute for Med. Res. and AMNJ*)

Dr. William D. Crecca

William D. Crecca, M.D., a member of our Essex County component, died at Clara Maass Memorial Hospital in Belleville—the hospital he helped to found more than two decades ago—on August 24. A graduate of New York University Medical College in 1917, Dr. Crecca had practiced surgery in Newark for 58 years. In addition to his affiliation with Clara Maass Hospital, he had been on the surgical staff at Martland, Presbyterian and Columbus Hospitals in Newark, and St. Barnabas Medical Center in Livingston. Dr. Crecca was a former president of the Essex County Medical Society and was founder of the Essex County Blood Bank in 1947 and became its first president. He was a Fellow of the American College of Surgeons and a member of the New Jersey Society of Surgeons and of the Academy of Medicine of New Jersey. Dr. Crecca was 85 years old at the time of his death. He was a 1967 recipient of MSNJ's Golden Merit Award marking the fiftieth year of practice.

Dr. Ralph S. Ferenchak

A member of our Union County component, Ralph S. Ferenchak, M.D., died on September 21 at his home. A native of Long Island, born in 1916, Dr. Ferenchak was graduated from Long Island University School of Medicine in 1942 and pursued a career in neurology. He was chief of the genito-urinary surgery department at Muhlenberg Hospital for many years before retiring in 1973 because of disability. Dr. Ferenchak was a Fellow of the American College of Surgeons and a member of the American Urological Association. He also was affiliated with Raritan Valley Hospital in Green Brook and the Veterans Administration facility at Lyons. Dr. Ferenchak was a Fellow of the American College of Surgeons and a member of the American Urological Association.

Dr. William E. Mountford

On September 2, William E. Mountford, M.D., a member of our Mercer County component, died at St. Francis Medical Center after a long illness. A native of Trenton, born in 1912, Dr. Mountford was graduated from Georgetown Medical School in 1938 and pursued a career in internal medicine with special interest in cardiology. He was a Fellow of the American College of Cardiology and had been affiliated with St. Francis Medical Center all of his professional career.

Dr. Henry Oshrin

One of Hudson County's senior members, Henry Oshrin, M.D., formerly of West New York died on August 22 in Pine Brook after a long illness. Born in 1902 and graduated from the University of Maryland School of Medicine in 1925, Dr. Oshrin practiced general medicine and surgery for over fifty years before retiring in 1976. He had been affiliated with Christ Hospital in Jersey City. In 1975 Dr. Oshrin received MSNJ's Golden Merit Award signifying fifty years of medical practice.

Dr. S. Lawrence Samuels

An ophthalmologist in Plainfield until his retirement in 1975, S. Lawrence Samuels, M.D., died on September 13 in Lauderhill, Florida. Born in New York City, Dr. Samuels received his medical degree from Cornell University Medical College, class of 1929. Prior to his retirement, he had been a clinical assistant professor in ophthalmology and ophthalmic surgery respectively at New Jersey Medical School and Rutgers Medical School, and had been affiliated with Muhlenberg Hospital, Plainfield, Rahway Hospital, the Jersey City Medical Center, as well as the New York Eye and Ear Infirmary and Manhattan Eye, Ear and Throat Hospital, both in New York City. Dr. Samuels was a diplomate

in ophthalmology, a Fellow of the American Academy of Ophthalmology and Otolaryngology, and of the American and International Colleges of Surgeons. During World War II he served in the medical corps of the Army of the United States. Dr. Samuels was 73 years old at the time of his death.

Dr. S. Robert Schiro

On September 8, S. Robert Schiro, M.D., a member of our Bergen County component, died in Hackensack Hospital. A native of New York City, born in 1910, Dr. Schiro was graduated from New York University Medical School in 1935. He pursued a career in surgery and had practiced in Hasbrouck Heights for 40 years. He had been affiliated with Beth Israel Hospital in Passaic and South Bergen Hospital in Hasbrouck Heights. Dr. Schiro was a member of the American Society of Abdominal Surgeons. He was active in civic affairs, and had been physician for the Hasbrouck Heights school district for 22 years and a town councilman.

Dr. Leonard J. Thalheimer

A member of our Union County component, Leonard Julius Thalheimer, M.D., died on September 19. Born in New York City in 1927, Dr. Thalheimer earned his medical degree at the University of Lausanne in Switzerland, graduating in 1957. Upon his return to the United States, he established a pediatric practice in Plainfield, and was affiliated with Muhlenberg Hospital in that city and Raritan Valley Hospital in Green Brook. Dr. Thalheimer also was an assistant clinical professor in pediatrics at Rutgers Medical School. He was a diplomate in pediatrics as well as a Fellow of the American Academy of Pediatrics. During World War II Dr. Thalheimer, prior to embarking on his medical career, served as a pharmacist's mate in the United States Navy.

Correlative Neuroanatomy and Functional Neurology.

17th Edition. Joseph G. Chusid, M.D. Los Altos, CA., Lange, 1979, pp. 464 (\$12.00).

If a textbook ever should get on a best seller list, this 17th edition deserves a place. Since 1938 the updates have eliminated slips and errors to an admirable degree. It is organized into major sections for easy cross-reference. Fast access to basic information would be enhanced by page references in the actual text of this concise, readable paperback. It is organized in a logical sequence for comfortable reading by anyone who wishes to have a rapid review. Little mention is made of controversy in theory or disease process. Pathological anatomy and basic anatomy include enough repetition under various headings to provide reinforcement of learning.

Although the text has been updated in places, many of the references are old. The appendix offers references by subject but the chapters might better have specific references to current titles. The author might better comment on what is the "best" text or paper to refer to in order to save space.

The essence of this book is its emphasis on the practical neuroanatomical basis of neurological diagnosis. Accuracy and readability of its 450 illustrations and 60 tables saves innumerable words. Basic anatomy is followed by succinct descriptions of clinical syndromes or clinical findings in lesions of a particular area of the brain, spinal cord or peripheral nerves. For the general medical reader, it is an excellent buy. As a diagnostic tool, its correlation of clinical findings with anatomical, physiological and chemical background, disease processes and pathological anatomy afford the reader the insight necessary to make a reasonable clinical diagnosis and to formulate a plan for further tests and treatment.

It is a readable review for the practicing clinician and an excellent reference manual for the non-neurologically oriented practitioner needing brief, uncomplicated guidelines for using the clinical information at hand.

Henry R. Liss, M.D.

The Courage To Live.

Ari Kiev, M.D. New York, Thomas Y. Crowell, 1979, pp. 148. (\$7.95).

This short book is written not for physicians or other professionals but for depressed individuals and their relatives and friends. It deals with the nature and treatment of depression with a more specific focus on suicide and the factors which lead the depressed person to take his life.

Dr. Kiev points out in the introduction that twenty-five to fifty thousand suicides occur in this country every year, and perhaps 250,000 attempt suicide annually. He emphasizes that the causes of suicide are personal, although the economic, social and political stresses often blamed for rising suicide rates may intensify a depressed individual's feelings to the point where he cannot bear living any longer. He goes on in the text to show how such a person may learn to direct his energies to find meaning and purpose in life, to choose life instead death.

The remaining chapters deal with the signs, symptoms and causes of depression and the kinds of chemotherapy and psychotherapy used in treatment. One chapter gives useful advice for families and friends. Others discuss crisis intervention, the slow suicide of alcohol abuse and other self-destructive living patterns, and how to discover and utilize one's inner potential.

Two appendices give guidelines for patients on chemotherapy and for selecting a psychotherapist.

The book is well written and provides an excellent guide for the depressed. Family physicians may find this worth recommending to depressed patients or their families; depressed physicians will benefit from reading it.

A. Arthur Sugarman, M.D.

Clinical Cardiology.

2nd Edition. Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. Los Altos, CA, Lange, 1979. Pp. 718. Illustrated. (\$17.50).

This book is a current version of a previous text on clinical cardiology published in 1977. The authors' reasons for publishing this second edition are to rectify errors and correct omissions as well as bring this excellent volume up to date in a field that advances with the speed of summer lightning.

The chapters (23) carefully divide the subject material into sections on physiology, investigative techniques, therapy, coronary heart disease, hypertension, heart failure, valvular heart disease, arrhythmias, myocardopathy, pericarditis and many others. The bibliography after each chapter further amplifies the content and provides complete coverage. The material is well constructed, artfully presented, carefully balanced for importance to the practitioner and written with literary grace so that one can read for enjoyment as well as knowledge. I appreciated the book in its original form and the appearance of the new edition also is welcomed.

New information in cardiology cascades from the journal and research laboratories in vast unbroken streams. The authors present much of this materi-

al in condensed practical form with special attention to coronary heart disease, exercise EKGs, cardiac catheterizations, echocardiography, mitral valve prolapse, new drugs for arthritis, pericarditis, hypertension treatment, sudden death and others too numerous to mention.

I recommend this book for all interns, residents and cardiologists.

Manuel J. Rowen, M.D.

Brain Surgeon: An Intimate View of His World

Lawrence Shainberg. Philadelphia, Lipincott, 1979, pp. 266. (\$10.95).

Perhaps my untempered enthusiasm

for *Brain Surgeon* is colored by my background as a neurosurgeon but, as a layman and reporter, Shainberg does a truly remarkable job. Putting aside the challenge to identify the medical center and the subject of the profile, one will find that the author subtly has woven into his narration profiles of the doctors, the patients and their families, affording in his description insight into their conflicts, their attitudes and personalities. He includes definitions, philosophy, history of the specialty, training requirements and attitudes, cleverly presenting case histories or technical explanations of the brain anatomy, pathology, tensions on both sides and techniques of diagnosis or treatment. He offers compassion, while dramatizing the social and psychological ramifications of brain

surgery.

Shainberg offers remarkable explanations of the brain and its functions in simple rememberable terms, comprehensible to the reader, and in small doses so as not to overwhelm. All is interwoven meticulously and sometimes dramatically in a tightly written book that considers the environmental influences of problems of the nervous system along with philosophical considerations.

Brain Surgeon deserves to be read by all who come in contact with neurodiagnostic tools, the operating room and the psychosocial problems of patients facing possible neural-science dead-ends. The writing is taut, the reading quick and the insights valuable.

Henry R. Liss, M.D.

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N. M. Finkelstein, M.D., New Brunswick*

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The cover picture of the Battle Monument in Trenton (see editorial, page 889, this issue) is from the Old Davis House private collection of Mr. and Mrs. Harold Simon of Lawrenceville, New Jersey. The approximate date is 1937; the photographer is unknown.

Note Dates
and Location

214th Annual Meeting
May 10-13, 1980
Meadowlands Hilton, Secaucus

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The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

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Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

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Featuring: What To Do If You Are Sued A Case Report MIENJ/NJ Trial Lawyers Meeting†

It has been one of those hectic days beginning with a 4 a.m. emergency call to the hospital, an office load that kept you busy through the day into late afternoon, a "sympathetic" call from your broker and now a letter from an unknown attorney. Several phrases glare back at you from the letter . . . "prosecute a claim for damages against you . . . arising out of medical malpractice . . . our medical-legal investigation indicates we have a probable cause of action against you for negligence . . . suggest you contact your insurance company!"

Your feelings normally will run from fury or rage to "how could someone do this to me!" This is the time to compose yourself, calm down, organize your thoughts and call your insurance company.

The following list is presented to aid you should you find yourself involved in a professional liability claim:

(a) When you call your insurance company be ready to describe the patient's reason for coming to you, the treatment rendered and its result. Depending upon your insurer, the claims person will make an appointment to interview you or schedule a peer review.

(b) If the claim extends over a period of time when you were insured by more than one company, (i) contact your current insurer, (ii) mention this fact to your current insurer.

(c) You will need to get copies of all pertinent medical records, including hospital records, ready for your meeting with the claims person.

(d) Review the records in order to clarify your thinking and to remind yourself of particulars to be discussed with the claims person. **It is most important that you do not change any of the records by supplementing, completing, or clarifying the contents.**

(e) Work closely with your insurance company and defense counsel; remain calm and follow directions.

(f) You should not contact or agree to meet with the plaintiff's attorney until you first have spoken to a representative of the insurer or your personal attorney.

(g) The patient or his family may want to further discuss the matter with you. Be accommodating and set up an appointment for a frank and full discussion of the problem. Maintain an open and a positive attitude throughout the discussions.

There are times when a physician may anticipate the filing of a claim by the patient or his family either by direct allegations or through an unanticipated outcome of treatment. When this possibility arises, the physician should call his insurance company and inform them of the situation. This allows the insurance company to begin preparation while the events are more accessible to recall by the physician.

Keep in mind that your professional liability insurance company is obligated to do its best for you in securing an attorney, establishing a defense, and working toward a fair conclusion of the claim.

CASE REPORT

"Recovery for Emotional Stress in Premature Birth of a Child"

(*Friel v. Vineland Obstetrical & Gynecological Professional Assoc.*, 166 N.J. Super. 579, 400 A.2d 147 (1979))

A New Jersey trial court has ruled that a mother who received compensable injury as result of alleged negligence could not only recover for her own physical injuries but also for those resulting from her emotional stress sustained due to the premature delivery of her child and the uncertainty of the child's normality during the formative years.

The suit alleges that the physicians who treated the mother throughout her pregnancy were negligent in obstetrical care and in their lack of attendance during labor, and that events surrounding the birth of the child may have caused oxygen deprivation resulting in possible brain damage.

The court observed that no final determination of the infant's injuries may be reached until the age of three to five years, when educational and psychiatric tests could be administered. The mother consequently would be subject to continuing uncertainty and emotional trauma. The court held that the mother was entitled to recover for her anxiety regarding the child's condition. The court emphasized that "because the mother and child were simultaneously injured by defendant's negligence, the emotional trauma resulting from the mother's own injuries was inseparable from the trauma resulting from the injuries to the child and the uncertainty as to whether the child was brain damaged." (*Professional Liability Reporter*, Aug. 1979)

Last year the New York State Court of Appeals ruled that physicians can be held liable for the lifetime costs of care for a congenitally deformed child^a born under such circumstances, but dismissed the parent's claim for emotional suffering.

The New Jersey court has taken a reverse position, feeling that a claim for lifetime costs is "wholly disproportionate to the culpability involved and . . . allowance of such a

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

†This item was prepared by Bernard H. Genest, Director of Claims Administration, MIENJ.

^aApproximately 275 defective or malformed children are born in this country every day. *United States Census*, 1975.

recovery would both constitute a windfall to the parents and place too unreasonable a financial burden upon physicians."

The case has been remanded for trial by jury to decide whether the physicians were negligent. Should the decision favor the plaintiff, the jury will decide on the amount of recovery.

DID YOU KNOW:

Eighty percent of all professional liability claims or suits have their origin in the hospital (A.H.A. 1979). Statistics from a malpractice study of 4000 claims conducted by HEW during a four-month period in 1976, and published in late 1978 revealed the following: Of the 4000 claims, 47 percent resulted in awards, 93 percent of which were over \$500 with the average award being \$27,000. Of the total number of physicians involved in a claim, 33 percent were surgeons, 20 percent were general physicians or family physicians, and 13 percent were obstetricians and gynecologists. The surgical specialty appearing most frequently was general orthopedic surgery. However, in proportion to their representation in the United States population, neurosurgeons ran the greatest risk of being named as defendants, being so named four times more than all specialties combined.

The MIIENJ reports, as of July, 1979, that, in proportion to the number of insured physicians, obstetricians and gynecologists account for 13 percent, orthopedists 10 percent and neurosurgeons 8 percent of claims. MIIENJ further reports that 13 percent of **all incidents** reported become a claim or suit. However, almost 50 percent of the incidents resulting in very severe injuries become claims and suits.

The MIIENJ was featured in the October 1 issue of *Medical World News* (p. 20):

"Doctor-owned Malpractice Plan Cuts Defense Costs" reported on a speech given by Bernard Genest, Director of Claims for MIIENJ, to a group of insurance executives and defense lawyers at a Defense Research Institute seminar in Chicago. James S. Todd, M.D., Board Chairman, and Peter Sweetland, President of MIIENJ, also were quoted on the novel features of the plan that "has cut defense costs 24 percent and slashed settlement time down to four and a half months—21 months under the national average."

CASE SURVEY

A ten-year-old boy was admitted to an emergency room complaining of pain in his right thigh resulting from an injury received while playing football. He was discharged as having a muscle strain. Several days later it was discovered that the patient had a dislocated right hip resulting in aseptic necrosis of the femoral head with possible loss of the hip.

It was found that the emergency room physician had taken an inadequate history as well as performed an inadequate physical examination. In addition, the resident and chief radiologist had misread the x-rays. The three physicians were found liable resulting in a substantial award to the plaintiff.

The proper questioning to elicit an adequate history as well as listening to the patient's complaint to gather information pertinent to the present difficulty, could eliminate many claims, particularly in an emergency room setting. It is well to remember that while an x-ray reading of "positive" is strong evidence of an abnormality, a negative result does not necessarily mean there are no abnormalities.

"The high rate of diagnostic error for incidents of trauma (i.e., fractures, other accidents and injuries) is illustrative of another problem. Many trauma cases are first seen and treated in the emergency room where individual cases are

often handled quickly and important decisions are made on the basis of often limited information. This is reflected by the larger than usual percentage of errors attributable to inadequate information (83 percent). Fractures, on the other hand, have a very high (34 percent) rate of misinterpretation errors. It seems likely that a large portion of the 34 percent represents misread x-rays in which a fracture was not noted on the films." (*Synopsis of the HEW/Industry Study, Medical Malpractice Claims, 1976*)

MIENJ AND NEW JERSEY TRIAL LAWYERS COOPERATE

Representatives of the Medical Inter-Insurance Exchange of New Jersey met with the Medical Malpractice Committee of the Association of Trial Lawyers of America, New Jersey Branch (ATLA) on September 14, 1979 to discuss mutual problems confronting them. ATLA attorneys usually represent plaintiffs in malpractice cases. On September 26 the ATLA Board of Governors adopted as a resolution the following recommendations that arose out of the earlier meeting:

(1) Plaintiff's attorneys, after the acceptance of the case, afford the MIIENJ ninety days within which to investigate claims rather than immediately filing suit;

(2) There be an open and complete discussion of the issues and a furnishing of experts' reports if same are in custody of plaintiff's counsel;

(3) Punitive damages not be randomly included in the complaint and that ATLA was opposed to the use of this Count merely for purposes of exerting pressure on the defendant;

(4) All complaints filed specify the allegations of malpractice and that the pleadings not be in general terms;

(5) Unnecessary defendants not be included and that ATLA was opposed to the shotgun approach of selecting defendants and recommended the use of Jane Doe—John Doe entities;

(6) In the event that MIIENJ indicates its willingness to settle a claim but an impasse arises concerning damages, that the matter be submitted to a mutually agreeable mediator but the results would not be binding;

(7) In all discussions relative to damages the specials be verified and documented by plaintiff's counsel.

Bernard H. Genest, Director of Claims Administration for MIIENJ, also agreed to verify insurance coverage on potential defendants so that plaintiff's attorney would know if MIIENJ's program applied and to supply copies of the doctor's office records prior to the institution of a lawsuit if the insured's cooperation could be secured.

MIENJ and ATLA also have agreed to set up a committee to discuss and deal with problems that arise between members of each organization. It was suggested that members of each organization speak at respective meetings to explain some of the problems encountered by both sides in handling these matters.

DEPARTMENT ACTIVITIES

Since our last issue, James E. George, M.D., J.D., Director of the Department of Professional Liability Control, has conducted medicolegal seminars for the New Jersey Urological Society and the NJ Chapter of the American Academy of Pediatrics. The DPLC has a seminar service available to assist in planning and presenting medicolegal seminars tailored to medical specialty needs. **Category I AMA credits are given for attendance at medicolegal seminars.**

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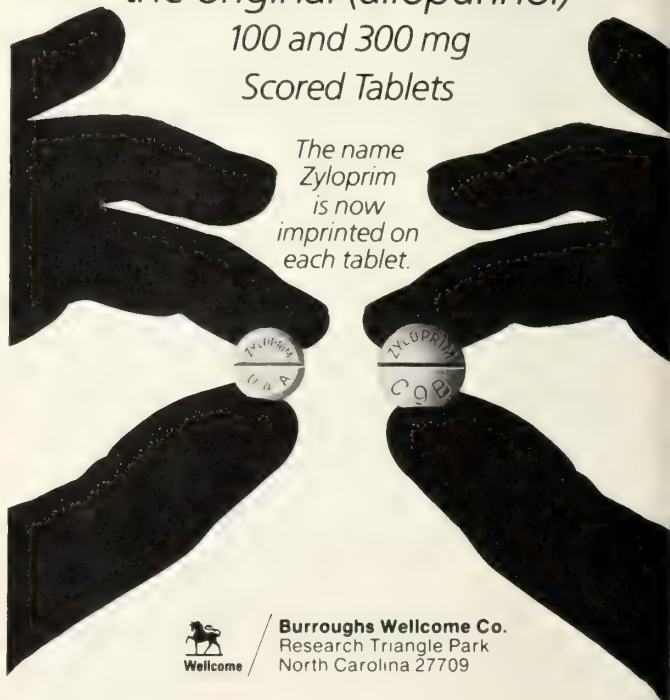
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Trenton Is Three Hundred

To New Jersey citizens, the Christmas season rekindles thoughts of the American Revolution and especially the events in and around Trenton. This year is special because Trenton, which has been involved in a great deal of American history, including a brief stint as the capital of the United States, is 300 years old.

Trenton is a part of the tract of land which was inhabited by the Lenni Lenape Indians when Mahlon Stacy and other Quakers from England arrived to establish a tiny village in 1679. Stacy, a well-to-do tanner from Yorkshire, seeking refuge from the religious persecution of that period in England, arrived in Burlington in December 1678. He had purchased more than 3,500 acres of good farming land along the Delaware River from William Penn and, with other members of the Society of Friends, he established a settlement known as "the falls of the Delaware." Stacy built a grist mill at the point where the Assunpink Creek entered the Delaware River and the community grew and flourished until 1714 when William Trent purchased 800 acres of Stacy's land from his son, Mahlon the younger. It was Trent who planned and laid out the streets and tracts into a townlet, which was called Trent's Town, later Trent-Town, and eventually Trenton.

The Battle Monument (pictured on our cover), a 155-foot phallus-like structure with a figure of Washington mounted at its vertex, was built between 1891 and 1893, to commemorate the role Trenton played in the Revolutionary War. It is located on the site of the Battle of Trenton, which some believe was a vital turning-point of the American Revolution.

Most of us are aware, at least in vague terms, of the events which transpired at that crucial point in our history, but a retelling will emphasize the passion and gallant patriotism of the participants.

Prior to the Battle of Trenton, both the British and many of the leaders of the newborn United States believed the rebel cause was doomed. New York City had been captured by the Redcoats, more than 2,600 men had been lost at Fort Mifflin, and, in December 1776, the dispirited troops under General George Washington's command were deserting in large numbers. The demoralization of his troops and the small new nation made it clear to Washington that he needed a spectacular victory to turn the tide militarily and emotionally. At a council of war on December 24, 1776, Washington issued the orders which led to the fantastic crossing of the Delaware River on Christmas night at McKonkey's Ferry, now known as Washington Crossing. The river was in full flood and jammed with massive chunks of ice when the General and his 2,400 men and 18 cannon

made the crossing in forty-foot Durham boats:

"The Durham boats shoved out into the awesome flood, laden with shivering men or with Henry Knox's guns and horses. Vast ice slabs crashed into the sides of the craft, lunged under bows, ripped into sterns, were fended off by Glover's men before they could smash down on the thwarts. And all the time oar and pole worked on in skilled, freezing hands—to the north bank, back to the south, to the north again.

"By four in the morning there were nine long miles to cover before wintry dawn. There was no smoking or talking or halting or straggling—surprise was essential on the road that led to sleeping Trenton and its garrison of tough German professionals."*

Brigadier General James Ewing and some 700 men and General John Cadwalader and 2,000 troops were to cross the Delaware at other locations and join Washington in battle, but neither Ewing nor Cadwalader made it across the river. The Continental troops marched on Trenton in two columns with Generals Greene and Washington on the left flank (Pennington Road) and General Sullivan on the right flank (River Road). Brigadier General Roche de Formoy traveled east along Princeton Road.

All was quiet in the small town of some one hundred scattered houses which was held by 1,400 German mercenaries commanded by Colonel Johann Rall. Christmas had been celebrated by huge amounts of German beer and heavy food, so the Hessians were slow to rouse from sleep until a picket on the Pennington Road "saw movement, then heard shots, running feet, shouts in the lightening air" at half-past seven.

Although the German garrison attempted to organize for the battle, in less than three-quarters of an hour, the affair was over:

"On high ground at present Princeton Avenue, Washington appeared with his staff and threw in Lord Stirling's brigade, spearheaded by George Weedon's Third Virginia. Americans under Captain William Washington and Lieutenant James Monroe (later to assume a far higher title) cut down the gunners about two Hessian fieldpieces. Arthur St. Clair's brigade was in, and John Stark, leading its right element, 'dealt death wherever he found resistance and broke down all opposition before him.'

"As their firearms dried out, riflemen took aim and muskets began to pop all along the line. Rall, still dazed from his holiday celebrations, raged up and down King and Queen

*Lancaster B: *The American Heritage Book of the Revolution*. New York, American Heritage Publishing Co., 1958, pp.188-189.

Streets, bravely trying to rally his men. Then he was down, mortally wounded. Washington moved immediately on as 'news of the Trenton victory ran through the Army and the country like a bolt of electricity.' ”*

Next time you come to the Medical Society headquarters or have business in Trenton, drive along Princeton Avenue and tip a finger at Washington and his revolutionary shrine.

A.K.

Running to Death

In a recently published newspaper cartoon, a middle-aged, obese, unathletic-appearing Frank, with crossed eyes, tongue hanging out, and droplets of sweat flying from his agonized face, gasped to his jogging companion, Ernest, "Trying to stay young has aged me ten years."¹ Since both Frank and Ernest appeared in the same cartoon feature the next day, one must conclude that they were *lucky* and survived.

President Jimmy Carter, whose photograph somewhat resembled the picture in "Frank and Ernest"¹ as he collapsed during a recent marathon race also was lucky. And our nation was lucky! It is just such persons under just such circumstances who become statistics in articles dealing with sudden death during jogging or running.

Although selected epidemiologic data have suggested that physical conditioning may reduce mortality from coronary heart disease (CHD), these data have been distorted and exaggerated by some persons with a bias—writers, sporting clothes manufacturers, and even some physician-runners—who translate the "suggestion" into "fact." A sober, even untrained look at the facts quickly convinces one that opinions for and against jogging as a CHD death protectant are subjective.

On the basis of known epidemiologic risk factors for CHD mortality, it is preposterous to give such magical power to a single modality—exercise—while ignoring the adverse effects of all the other concomitants including stress and competition, hyperlipidemia, smoking, hypertension, diabetes, obesity, personality type and genetic factors.

After a careful study of eighteen individuals (17 male, one female) who died during or immediately following jogging or running, the staff of the prestigious Stanford Heart Disease Prevention Program shed some additional light on the subject.² In this group of persons, all of whom were 42 years of age or older, thirteen died of CHD while five died of other causes. One of this non-cardiac death group died of "heat stroke," while the cause of death was unclear in three cases.

The histories of six of the CHD subjects who died were significant and included hypertension, hyperlipidemia, cardiac arrhythmia, diabetes, and smoking. Four of the eighteen subjects had been exercising regularly for at least a year and nine had exercised three or more years.²

Thompson *et al.* were struck with the fact that six of the CHD cases had prodromal symptoms, i.e., the appearance of *new symptoms which were ignored*. The author found that competition definitely could be implicated as a factor in the runner who died of heat stroke.²

President Carter, who we are told jogs daily and is in good physical condition for his age, entered a competitive race and, despite the presence of his physicians and others, pushed himself beyond his endurance. He collapsed, presumably as a result of fluid loss, hypovolemia, electrolyte imbalance, and hypotension. The cardiovascular, peripheral vascular and cerebrovascular effects of his major stress are

not known to us. However, treatment with intravenous fluid and electrolytes and rest was successful.

There undoubtedly were warning signs and symptoms—or prodromata—during Carter's run, which were ignored. This, coupled with the competitive nature of the run and the age and physical status of the President, led to an early stage of heat stroke. Fortunately, he collapsed early enough so that treatment was able to reverse the disturbed physiology and metabolism before permanent injury or death occurred.

This form of poor judgment under stress could have deprived our nation of a President-in-office as emphatically as an assailant's bullet has done in the past. Had it done so, at a time of SALT treaty negotiations, the Cuban crisis, the United States monetary difficulties, and the energy muddle, our nation would have been exposed to great threats.

The Thompson study implied that:

—"Exercise deaths do occur, and there is no definite way to identify asymptomatic individuals at risk."

—"Long-term endurance training and superior physical fitness do not guarantee protection against such deaths."²

Neither presidents nor plain people should be permitted to swallow the extravagant claims made by some jogging and exercise enthusiasts. Despite the fact that President Carter may have set America's jogging industry back a few paces, all physicians do accept the concept that regular physical, recreational, and conditioning exercise may have some healthful benefits, which as yet have not been defined clearly.

In the final analysis, the physician should prescribe physical conditioning for each patient on an individual basis while keeping certain caveats in mind:

—Individuals should have a thorough review of their history and a physical examination looking for risk factors of CHD and sudden death before embarking on a program.

—A stress electrocardiogram may be desirable, but it is far from foolproof. The more expensive and less available thallium 201 myocardial scan and the multiple-gated blood pool scan with radioactive technetium Tc 99m are better.³

—Since patients may exercise poor judgment through the mechanism of denial, the physician should reevaluate his patient's history after a period of exercise and specifically look for prodromal symptoms. He should school the jogger thoroughly on the nature of prodromal symptoms and the need for prompt treatment should they appear.

The bottom line, however, of all the algorithms of treatment is that good *clinical judgment* by the physician and good *common sense* by the jogger are essential.

A.K.

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Bronchodilator Effects of Oral Salbutamol and Theophylline-Salbutamol Combinations in Chronic Steroid-Dependent Asthmatics

BENJAMIN H. SAFIRSTEIN, M.D.,
RAJ B. DHAKHWA, M.D., BRUCE GELB, B.S.,
F. DANA FORTUNATO, M.D., Newark*

Salbutamol is an efficacious bronchodilator when used in doses of four and six mg. to steroid-dependent asthmatics. The addition of theophylline provided little additional bronchodilator activity. No significant side effects were documented following single, oral doses of salbutamol alone or in combination with theophylline.

Adrenergic agents are important in the treatment of patients with reversible diffuse airway obstruction. Ahlquist first postulated that there were two types of adrenergic receptors¹. The stimulation of the alpha receptors was responsible for vasoconstriction while the beta receptor was responsible primarily for increases in heart rate, cardiac contractility, and bronchodilatation. More recently, Lands in 1967 suggested that there were Beta 1 and Beta 2 receptors². Among its other effects, the Beta 1 receptor controls cardiac stimulation whereas the Beta 2 receptor is responsible for bronchodilatation. As a result of these findings, interest in producing new drugs with selective Beta 2 stimulating effects increased over the last few years. Salbutamol, a selective Beta 2 stimulator, was introduced in 1968 and was found to be superior to isoproterenol hydrochloride because of its prolonged action and freedom from cardiovascular side effects.³ While extensive clinical trials have demonstrated the effectiveness and safety of salbutamol, there is a lack of clinical information concerning its effectiveness when combined with theophylline.^{4,5} Therefore we decided to perform a clinical trial of salbutamol in combination with theophylline and to compare therapeutic and unwanted effects against those of placebo, ephedrine, and ephedrine-theophylline combinations following oral administration.

This report documents the bronchodilator activity of single-dose salbutamol and theophylline combination in

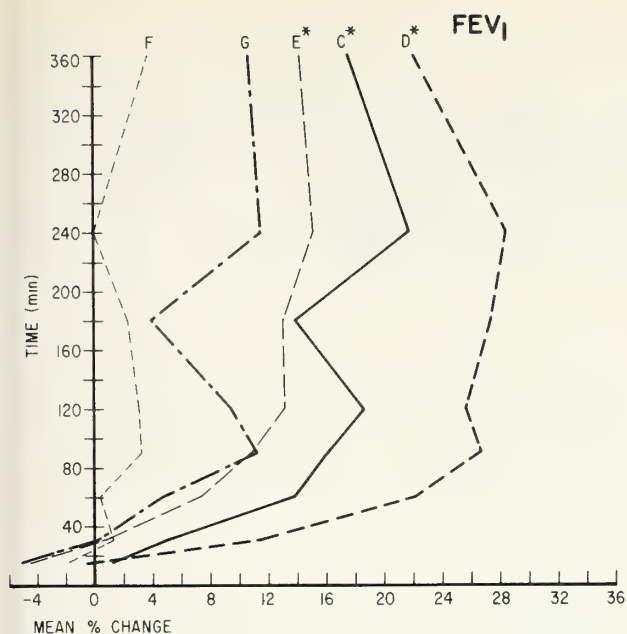
steroid-dependent asthmatics.

MATERIAL AND METHODS

Sixteen adult volunteers who had evidence of diffuse reversible airway obstruction were accepted for the study. All patients were in a stable clinical state and informed consent was obtained before the trial. Patient selection was based on greater than five hospitalizations per year and/or greater than ten emergency room visits per year, and/or greater than 30 days per year absence from work, or school, due to disabling asthma. Patient age ranged from 20 to 50 years; there were nine females and three males. Seven were classified as intrinsic asthmatics, and five as extrinsic asthmatics. All patients were maintained on prednisone at an average daily dose of 7.5 mg.

The diagnosis of diffuse reversible airway obstruction was defined as an observed value less than 80 percent of predicted value in at least one of the following parameters: forced expiratory volume (FEV₁) in one second and forced vital capacity (FVC). The subjects selected had shown a greater than 15 percent improvement in FEV₁ following administration of two inhalations of isoproterenol hydrochloride from an aerosol inhaler. If the baseline FEV₁ immediately

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*AT 360 PT., n=11

Figure 1—Represents single doses of the drugs: F—placebo; G—ephedrine 25mg.; E—theophylline 150mg.; C—salbutamol 4 mg.; D—salbutamol 6 mg.

prior to the drug administration was greater than 80 percent of the best FEV₁ value recorded by the patient during the prior three month period, the study day was postponed. Also, if the baseline pulse rate was greater than 110 beats per minute, the study day was postponed. Subjects with active pulmonary disease were excluded from the study. All were screened with routine hematology, SMA-12, urinalysis and 12-Lead electrocardiograms. Cardiovascular, hepatic and renal functions were within normal limits. All bronchodilator drugs were withheld for at least 12 hours prior to determination of baseline measurements for each study day.

Following a light breakfast, baseline pulse rate, blood pressure, FEV₁ and FVC were determined at 30 minutes and immediately before administration of the drug. The FEV₁ and FVC were measured on a Vitalograph® at ATPS.^a For all determinations of FEV₁ and FVC the subjects performed the maneuvers three times in a standing position. The curve with the highest FEV₁ determination was taken. In case of a tie, the curve with the higher FVC was used.

On each study day, the patients received doses of placebo, combination drugs or single drugs as tablets or capsules as listed below in randomized double-blind Latin Square design.^b

The treatments were:

1. Salbutamol 4mg; theophylline 150mg; ephedrine placebo (Curve A).
2. Salbutamol 6mg; theophylline 150mg; ephedrine placebo (Curve B).
3. Salbutamol 4mg; theophylline placebo; ephedrine placebo (Curve C).
4. Salbutamol 6mg; theophylline placebo; ephedrine placebo (Curve D).
5. Salbutamol placebo; theophylline 150mg; ephedrine placebo (Curve E).
6. Salbutamol; theophylline; ephedrine placebo (Curve F).
7. Salbutamol placebo; theophylline 150 mg; ephedrine 25 mg (Curve H).

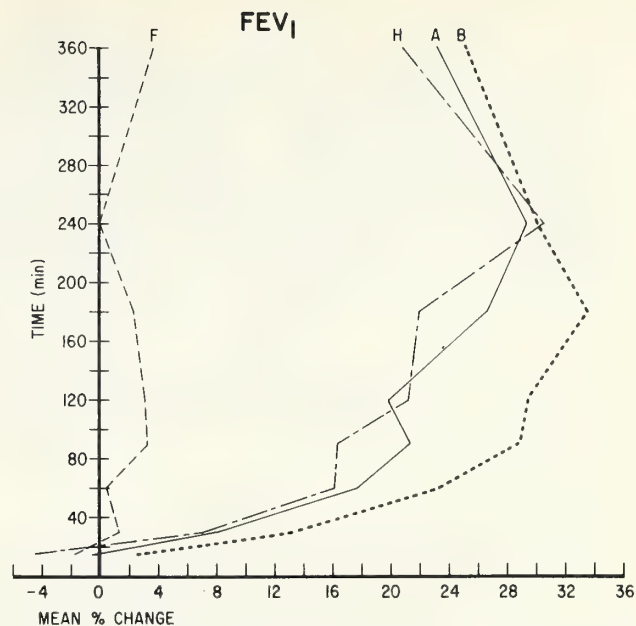


Figure 2—Represents combination drugs: F—placebo; H—theophylline 150mg./ephedrine 25mg.; A—salbutamol 4mg./theophylline 150 mg.; B—salbutamol 4mg./theophylline 150mg.

8. Salbutamol placebo; theophylline placebo; ephedrine 25mg (Curve G).

Following drug administration, pulse rate, blood pressure, FEV₁ and FVC were determined at 15, 30, 60, 90, 120, 180, 240, and 360 minutes. No other bronchodilator drugs were given during the time unless the patient was in acute distress.

The mean percent change in FEV₁ at a given time following a particular treatment was compared to the mean percent change in FEV₁ at the same time under a different treatment. Analyses were made at 30, 60, 120, 180, 240 minutes. All statistical analyses were done with a two-tailed T-test for correlated samples.

RESULTS

Twelve patients completed the study, but four failed because of poor compliance. No patient discontinued therapy because of unwarranted side effects.

Figure one compares time versus mean percent change in FEV₁. Curve F represents placebo alone. Ephedrine (G) at 25mg. demonstrated no statistically significant improvement in FEV₁ over placebo alone, at 60, 120, 180, and 240 minutes. Theophylline 150 mg. (E) provided significant increases in FEV₁ at 120 and 240 minutes. Salbutamol in 4mg. dose (C) demonstrated significant increase in FEV₁ at two, three, and four hours over placebo. Both four and six mg doses of salbutamol were significantly better than ephedrine and theophylline alone at 120, 180, and 240 minutes. The combination of salbutamol four mg. and theophylline 150mg. (Figure 2-A) did not demonstrate any significant improvement in FEV₁ as compared to four mg. salbutamol alone (C). The combination of six mg. salbutamol and 150mg. theophylline (B) showed no significant superiority over four mg. salbutamol 150mg. theophylline combinations, or four mg. salbutamol alone.

No significant alterations in blood pressure or pulse could

^aAtmospheric Temperature Pressure Saturation

^bAll drugs were supplied and packaged by the Schering Corporation, in Bloomfield, New Jersey.

"No significant alterations in blood pressure or pulse could be attributed to salbutamol. There were no reported headaches, palpitations, abdominal cramps, or tremors throughout the study."

"Salbutamol is an efficacious bronchodilator when used in doses of four and six mg."

be attributed to salbutamol. There were no reported headaches, palpitations, abdominal cramps, or tremors throughout the study.

DISCUSSION

Salbutamol is an efficacious bronchodilator when used in doses of four and six mg. It is superior to ephedrine or theophylline when used alone. Its bronchodilator activity is immediate and long acting. The addition of theophylline to salbutamol offers no significant improvement over salbutamol alone. The use of salbutamol either alone or in combination with theophylline in single doses produces no unwarranted side effects at doses that produce significant bronchodilatation when given orally to steroid-dependent asthmatics.

SUMMARY

A double-blind study comparing the bronchodilator efficacy of salbutamol alone and in combination with theophylline was undertaken in sixteen adult chronic asthmatic

patients. The study demonstrated that four and six mg of salbutamol were more efficacious than ephedrine and placebo. The addition, however, of aminophylline failed to provide any significant further bronchodilator activity. No untoward side effects were documented with single or combined doses of salbutamol.

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Percutaneous Liver Biopsy: Ten-Year Experience in a Community Hospital

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Seven hundred and thirty-one percutaneous liver biopsies, performed during a ten-year period from 1968 through 1977 in a community hospital, were reviewed. In the community hospital, the risk factors of needle biopsy of the liver are substantially larger, as compared to specialized centers, and the procedure often is delayed in many diagnostic problems, where it is of proved value.

The value and safety of the percutaneous needle biopsy of the liver performed in a university hospital setting has been established by several large studies.¹⁻¹⁰ There is, however, a paucity of information in the literature concerning this technique in general community hospitals. In this paper, we report a ten-year experience with percutaneous liver biopsy in a 370-bed community hospital in northern New Jersey.

MATERIALS AND METHODS

Seven hundred and thirty-one needle biopsies of the liver, performed at Holy Name Hospital during a ten-year period from 1968 through 1977, were culled from the surgical pathology files. In addition to the liver biopsies, all the surgical pathology and cytology material of these patients in our files was reviewed. The data for the complications and the morbidity of the procedure were gathered from patient charts and autopsy protocols. During the first half of the study, most liver biopsies were performed by internists; in the later half, two gastroenterologists assumed an expanding role in the investigation of hepatic disorders. The Vim-Silverman needle was generally used by the internists, while the Menghini needle was employed by the gastroenterologists. The characteristic histologic features of the various disease categories formed the basis of the morphologic diagnoses. These were corroborated by the clinical data and the tests of liver function including serum levels of aminotransferases (SGOT, SGPT), gamma glutamyl transpeptidase, total and direct bilirubin, total proteins, globulins, and hepatitis-associated antigen.

In each case, multiple three- to four-micron thick sections of the liver biopsy stained with hematoxylin and eosin were studied with light microscope. The fibroconnective framework of hepatic parenchyma was evaluated with trichrome and reticulin stains in all instances of viral hepatitis, alcoholic liver disease, and cirrhosis. Additionally, amyloid, iron, PAS, and Shikata-Orcein stains were employed when indicated.

RESULTS

Adequacy of the Specimen—For the period studied, the total number of liver biopsies performed and the failure rates (defined as absent or insufficient hepatic parenchyma in the specimen obtained) are given in figure 1. The failure rates fell dramatically from 26 percent for the first year of the study to two percent for the last year.

Disease Entities—The spectrum and frequency of diseases histologically diagnosed by liver biopsy are shown in table 1. The cirrhosis-hepatitis category (including alcoholic and viral hepatitis) accounted for 30 percent in this study. When the patient gave a "positive" history of alcohol abuse,

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and the biopsy demonstrated a fatty change with acute polymorphonuclear reaction, the existence of alcoholic liver disease was suspected. The histologic diagnosis of alcoholic hepatitis, however, was rendered only when the classic features of fatty change, inflammatory infiltrate, necrosis, and alcoholic hyaline in the central zones of the hepatic lobules were present. In 93 of 97 patients with ascending pericholangitis, the existence of calculus or neoplastic biliary tract disease, or some other intraperitoneal inflammatory process, was proved by subsequent surgical exploration and/or autopsy, or was supported by the clinical course and the laboratory data. In this category, the needle liver biopsy frequently was not considered early in the diagnostic work-up; it usually was obtained after additional consultation was sought and a delay of four to seven days had been incurred.

Morbidity—Blood transfusions for hypotension or clinical evidence of bleeding were administered in 16 (2.2 percent) instances. Regrettably, the clinical records were incomplete in many cases regarding the occurrence of complications such as pain requiring analgesics, and supportive measures such as intravenous fluids and hypotension returning to normal levels of blood pressure with or without therapeutic measures.

Mortality—Three patients died from biopsy-related causes (mortality rate 0.41 percent). All three deaths occurred among the 599 patients biopsied with the Vim-Silverman technique (mortality rate 0.5%); by contrast, no fatalities were encountered among the remaining patients investigated with the Menghini procedure. The three deaths are summarized as follows:

Patient #1—(1968) 68 year-old male; serum bilirubin, 8 mg/dl; liver biopsy, acute pericholangitis; third post-biopsy day, abdominal distension, hypotension, rapid deterioration, and death; autopsy: bile peritonitis and common bile duct obstruction by carcinoma of ampulla of Vater.

Patient #2—(1975) 50 year-old female; liver biopsy, post necrotic cirrhosis; clinical evidence of intraperitoneal bleeding and hypotension within six hours; surgical exploration: large tear in portal vein, massive intraperitoneal hematoma, and severe distortion of regional anatomy by adhesions (previous cholecystectomy); post-operative disseminated intravascular clotting and death within 29 hours of liver biopsy.

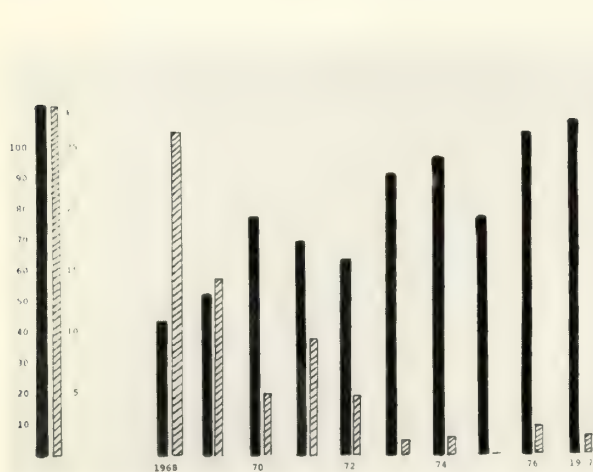


Figure 1—The yearly number of percutaneous needle biopsies of the liver (solid bars) and the failure rates (absent or insufficient hepatic tissue for the diagnosis as percentage of the total, striped bars) for the years 1968 through 1977 are shown.

Patient #3—(1976) 65 year-old female; liver biopsy, ascending pericholangitis; hypotension on third post-biopsy day; surgical exploration: intrahepatic hematoma and cholelithiasis; postoperative bleeding from duodenal ulcer; partial gastrectomy and vagotomy on fifth post-biopsy day; continued bleeding in gastrointestinal tract, shock and death on sixth post-biopsy day.

DISCUSSION

The value of needle biopsy of the liver as an investigative tool remains unsurpassed in the study of primary hepatic diseases and many systemic disorders with involvement of the liver. Accurate sampling of almost all the diffuse, and the majority of the focal lesions, with this technique has been documented.^{1, 3, 11, 12} The probability of securing a satisfactory specimen has been related, among other elements, to the experience and skill of the investigator. Not unexpectedly, the failure rates have plummeted from 10¹³ to 40 percent¹⁴ in earlier reports to less than two percent^{7, 15} in recent reports. The morbidity rates of this procedure have ranged from 5.8⁷ to less than one percent,¹⁶ the mortality rates from 0.17 percent² to zero.^{7,8} The availability of simpler and safer needles, observance of proper indications and contraindications, and an increase in personal experience in biopsy technique and interpretation have made needle biopsy an accepted procedure. Although the method is relatively easy, complications can occur, so needle biopsy should be approached with caution and regarded as potentially hazardous. The factors which may determine risk are the duration of the intrahepatic phase, the size of the needle, the experience of the operator, and the type of disease for which the biopsy is being performed. Bleeding is the most serious complication of the needle biopsy of the liver.^{2, 4, 7, 16} In most instances, bleeding occurs into the peritoneum; less commonly intrahepatic hematoma formation and hematuria may ensue.

Among our staff, during the decade under study, there was a dramatic improvement in the technical skill necessary for obtaining diagnostic hepatic tissue; with a steady increase in the number of biopsies performed, there was a sustained decline in the failure rate. In part, this may be attributed to

Table 1
Histologic diagnoses
of 731 percutaneous liver biopsies

Disease	Number of Cases	Percentage of Total
Neoplasms*	127	17.3
Cirrhosis	125	17.1
Ascending Pericholangitis	97	13.2
Fatty change (with or without mild inflammation)	71	9.7
Viral Hepatitis	57	7.8
Alcoholic Hepatitis	40	5.4
Hemochromatosis & Hemosiderosis	10	1.3
Drug-induced Injury	5	0.65
Granulomatous Hepatitis	5	0.65
Miscellaneous**	9	1.2
Mild non-specific inflammatory reaction	96	13.1

* Metastatic carcinoma, 113; lymphomas 9; hepatocellular carcinomas 5.

** Myeloid metaplasia, 3; sarcoidosis, Von-Meyenberg complexes, amyloidosis, and severe passive congestion—one each.

"The analysis of our morbidity and mortality rates disclosed that the risk factors which attend this procedure are substantially larger in a community hospital than in a university hospital setting."

"The need for developing a safe protocol for this procedure and greater vigilance against its various complications is highlighted."

the addition of two gastroenterologists to the staff at about the middle of the study period. The analysis of our morbidity and mortality rates, however, disclosed that the risk factors which attend this procedure are substantially larger in a community hospital than in a university hospital setting: need for blood transfusion 2.2 vs. 0.2⁷ to 0.6 percent¹⁶; mortality rates, 0.41 vs. zero⁷, 16 to 0.17 percent.² The risk of fatal complications of the liver biopsy with the one second technique introduced by Menghini has been reported to be significantly lower than that of previous methods including Vim-Silverman technique: one death in every 6615 biopsies in a total of 79,381 with the former procedure,¹⁷ and one death in every 538 biopsies in a total of 20,016 with the latter.² It is noteworthy that all three deaths in this study were related to the Vim-Silverman technique, giving a high mortality rate of 0.5 percent for this procedure alone.

Our data for viral and alcoholic hepatitis and cirrhosis (30 percent) are comparable to those from some university centers (37.7 percent⁷). The difference in these figures is attributable, in part, to referral of some patients with viral hepatitis from our hospital to larger institutions in New York City. Our histologic criteria for the diagnosis of alcoholic hepatitis were very stringent and resulted in a relatively low figure for alcoholic hepatitis and a high one for fatty change. By contrast, our figure for the diagnosis of neoplastic disease by needle biopsy was almost one-half (17.3 percent) of that in some other series (33.6 percent).⁷ This was not a surprise finding. From our surgical pathology and autopsy experience, we had been aware of the missed opportunities of histologic diagnosis of primary and metastatic neoplasms by liver biopsy in several instances.

In conclusion, needle biopsy of the liver in a community hospital, where a larger number of physicians is performing fewer biopsies, seems to carry a double indemnity: the risk factors are significantly greater than those in established gastroenterology facilities; and not infrequently, an unnecessary delay is incurred in obtaining the biopsy. The need for developing a safe protocol for this procedure and greater vigilance against its various complications is highlighted.

SUMMARY

Seven hundred and thirty-one percutaneous liver biopsies performed during a ten-year period from 1968 through 1977 in a community hospital were reviewed. The rate of unsuccessful biopsies (hepatic parenchyma absent or insufficient for evaluation) fell from 26 percent for the first year to two percent for the last year of the study. Three deaths from biopsy-related causes (mortality rate, 0.41 percent) are summarized. Blood transfusion was required in 16 (2.2 percent)

instances. The number of biopsies in the hepatitis-cirrhosis category (30 percent) was comparable to that reported from some university centers. By contrast, the diagnosis of neoplasms (17.3 percent) was made in about one-half as many instances indicating apparent failure on the part of many primary physicians to avail themselves of this investigative approach.

In the specialized centers, the safety and the diagnostic value of needle biopsy of the liver is well established; in the community hospital, the risk factors are substantially larger, and the procedure is often delayed, apparently by default, in many diagnostic problems where it is of proved value.

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Screening for Hypertension in Newark: The New Jersey Medical School's Experience*

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Over a two-year period 13,912 self-selected Newark residents were initially screened for hypertension. Approximately 24 percent had pressures equal to or greater than 160mm Hg systolic and/or 95mm Hg diastolic. Among blacks one in six aged 25 to 44, almost one in three aged 45 or older, had a diastolic pressure of at least 95mm Hg. Despite these data there is no concerted effort in this city whose population is predominately black to attack what is clearly one of the most important medical abnormalities.

Hypertension is a major public health problem in the United States, the current estimate being that 25 to 35 million Americans have the disease.^{1,2} The Veterans Administration studies clearly show that early detection and treatment reduce both the morbidity and mortality in those whose hypertension is severe.^{3,4}

The following is an analysis of data from the Hypertension Screening Program of the Department of Preventive Medicine and Community Health, New Jersey Medical School, Newark, New Jersey, from its start on March 15, 1974, through June 1976.

METHOD

The screening program was open to individuals 15 years and older at sites in key locations throughout the City of Newark. Screening locations were arranged by the Department of Preventive Medicine and Community Health's community organizer with the cooperation of local merchants, bankers, and civic and community organizations. Sites were selected for their accessibility to the community. Community organizations and block associations were utilized to help bring the service into neighborhoods and to assist in getting neighborhood residents to take advantage of this free health service.

The testing was conducted by the Department of Preventive Medicine and Community Health's family health workers. These six women from the Newark community were

given six weeks of training by nurse coordinators. They were certified by a medical school faculty nephrologist who also acted as medical director of the screening program. The training included discussions on the etiology of the disease, interviewing techniques, measurement of blood pressures and health education counseling.

Individuals participating were self-selected. Blood pressure was taken for each person in a sitting position and recorded to the nearest two mm Hg. Systolic pressure was recorded at the first perception of, and diastolic at the fifth phase (i.e., the disappearance) of the Korotkoff sound as is recommended by the Second Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. Those individuals screened and found to have a diastolic blood pressure greater than 90mm Hg and/or systolic pressure greater than 160mm Hg were referred to a physician or clinic for follow-up.

All information concerning the screenee was maintained and stored in the program's computerized hypertension registry. As a member of the New Jersey Educational Computer Network, New Jersey Medical School's staff has privileged access to an IBM S/370-168 and IBM S/370-158 via remote batch terminals at the two major campuses and via time-sharing terminals. A professional computer staff is

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“During the study we screened 3.1 percent (2,509) of the white male residents of Newark, 4.0 percent (3,498) of the white female residents, 3.2 percent (3,105) of the black male and 4.3 percent (4,800) of the black female residents.”

“Almost 9.7 percent of the residents screened had both a systolic pressure of 160mm Hg or greater and a diastolic pressure of 95mm Hg or greater.”

maintained to assist researchers in utilization of these resources. This allowed the program to maintain up-to-date information on each screenee such as address and whether hypertension was confirmed. It also allowed us to generate statistical data on our screening activities. All information on each person screened was held in strict confidence. Chi-square on 2x2 contingency tables and sine tests were used to test all statistical data.

At the beginning of the program, letters were sent to community physicians and the Newark hospitals requesting that the program be allowed to refer individuals with elevated blood pressures to their service for confirmation of blood pressure readings and possible medical treatment if needed. Each of the four major hospitals in Newark participated along with three greater-Newark area physicians. These providers' services were compiled into a referral listing and any individual who wished to have assistance in seeking further medical care was shown the listing. Each listed service was explained so that the screenee could choose from the listing or seek medical care from some other source such as the Essex County Medical Society.

RESULTS

During the course of the study we were able to screen 3.1 percent (2,509) of the white male residents of Newark, 4.0 percent (3,498) of the white female residents, 3.2 percent (3,105) of the black male and 4.3 percent (4,800) of the black female residents. No attempt was made to determine whether these were demographically representative of the total population in each of the four sub-groups.

Table 1 shows that of 13,912 black or white Newark residents who were screened, approximately half had systolic pressures under 140mm Hg and diastolics under 90mm Hg. Hispanic and other racial and ethnic groups were not shown in this analysis since the samples were too small. An additional 40.1 percent had either a diastolic pressure at least 90mm Hg and/or a systolic pressure of 140mm Hg and above. Almost 9.7 percent of the residents screened had both a systolic pressure of 160mm Hg or greater and a diastolic pressure of 95mm Hg or greater. The data on Table 2, which pertains specifically to diastolic pressures, indicate that 18 percent of the blacks screened had diastolic pressures greater than 95mm Hg, while 15 percent of the whites screened had diastolic pressures greater than 95mmHg. Table 3 indicates that the proportion of screenees with systolic pressures above 160mm Hg and/or diastolic pressures over 95mm Hg generally was similar among men and women.

The following data suggest the severity of the problem in Newark. Eleven percent of the screenees had diastolic pressures between 95-104mm Hg and six percent had diastolic pressures greater than 105mm Hg. Ten percent had systolic pressures greater than 160mm Hg and diastolic pressures

greater than 95mm Hg. Approximately 0.1 percent had diastolic pressures 140mm Hg and over and systolic pressures of 160mm Hg and over.

We then examined age and race specific rates for systolic and diastolic hypertension (Table 4). In persons 15 to 34 years old, there was a slight tendency for a greater percentage of whites to have substantial systolic hypertension (defined as greater than 160mm Hg); but this was dramatically reversed in the 35 to 54 year old categories ($p < .001$, chi square). More than one of five blacks in the 45 to 54-year-age group had a systolic pressure of greater than 160mm Hg.

Blacks showed more diastolic hypertension in these age groups. Among blacks age 25 to 44, one in six had diastolic pressures of at least 95mm Hg. This proportion increased to almost one in three among those over 45 years of age ($p < .001$).

Midway through the study a follow-up evaluation was begun. At that period, 4,598 had been screened. The follow-up was conducted to determine if those screened and designated as possibly hypertensive had adhered to our advice concerning further evaluation. It was decided to generate a computer printout of all screenees at the time who had diastolics of 90mm Hg or greater. This was the only variable used. In this group, 1,156 persons had initial diastolic pressures of 90mm Hg or above and had been asked to visit their physicians or an appropriate clinic. Of these, 1,156 (40 percent) did not respond to the questionnaire; in an additional 31 percent the letters were returned undelivered by the post office indicating that a large number of persons in this inner city population had given incorrect home addresses. Of the 29 percent who did respond, 86 percent had seen a physician and were told they were hypertensive. It was decided that 75 of the 288 who stated their physician had confirmed our findings would be selected randomly and their physician contacted by our staff. In each case their physician confirmed they were hypertensive.

DISCUSSION

Epidemiologic surveys of blood pressure in the United States have shown that 15 percent of the whites and 30 percent of the blacks have diastolic blood pressures greater than 90mm Hg.⁵⁻⁷

In our screening program about 17 percent of those screened had systolic blood pressures of 160mm Hg and above and approximately 15 percent had diastolics over 95mm Hg. If 95mm Hg diastolic and/or 160mm Hg systolic are used as arbitrary cutoff points for designating an individual hypertensive, then 24.3 percent of those screened had evidence of elevated blood pressures. Among those over age 25, diastolic hypertension was far more frequent among blacks.

Our findings generally were similar to those found in other

Table 1
*The Distribution of Systolic and Diastolic Blood Pressures in the
 Newark, N.J. Screening Program, 1974-1976*

Diastolic Blood Pressure (mm Hg)	Systolic Blood Pressure (mm Hg)																
	< 140				140 - 159				160 - 180				≥181				Total
	WM	WF	BM	BF	WM	WF	BM	BF	WM	WF	BM	BF	WM	WF	BM	BF	
Less than 90	1,019	1,535	1,647	2,693	331	512	253	346	117	189	53	114	12	28	5	11	8,865
90 - 94	171	171	235	305	294	381	259	374	128	175	59	110	10	32	6	11	2,721
95 - 104	30	19	41	52	99	119	153	217	119	175	111	195	32	43	17	42	1,464
105 - 119	2	6	3	7	34	7	49	55	51	54	77	111	28	28	25	58	595
120 - 140	—	—	—	1	1	0	5	3	4	7	25	27	18	12	42	36	181
141 and over	5	1	29	19	1	3	9	5	1	1	1	5	2	0	1	3	86
Total	1,227	1,732	1,955	3,077	760	1,022	728	1,000	720	601	326	562	102	143	96	161	13,912

WM = White Male BM = Black Male
 WF = White Female BF = Black Female

Table 2
*The Distribution of Diastolic Blood Pressure
 by Sex and Race, Newark, N.J., 1974-1976*

Diastolic Blood Pressure (mm Hg)	Black			White		
	Male	Female	Total	Male	Female	Total
< 95	2,517 (81%)	3,964 (83%)	6,481 (82%)	2,082 (83%)	3,023 (86%)	5,105 (85%)
≥ 95 - 104	322 (10%)	506 (11%)	828 (10%)	280 (11%)	356 (10%)	636 (11%)
≥ 105 - 119	154 (5%)	231 (4%)	385 (5%)	115 (5%)	95 (3%)	210 (3%)
≥ 120 - 140	72 (2%)	67 (1%)	139 (1.8%)	23 (0.9%)	19 (0.5%)	42 (0.7%)
≥ 141 and over	40 (1%)	37 (0.7%)	72 (0.9%)	9 (0.4%)	5 (0.1%)	14 (0.2%)
Total	3,105	4,800	7,905	2,509	3,498	6,007

Table 3
*Distribution of Systolic Blood Pressure by Race,
 Newark, N.J., 1975-1976*

Systolic Blood Pressure (mm Hg)	White			Black			Total
	Male	Female	Total	Male	Female	Total	
< 160	1,986 (79%)	2,750 (79%)	4,736	2,659 (86%)	4,013 (85%)	6,672	11,408
≥ 160	509 (21%)	737 (21%)	1,246	418 (14%)	722 (15%)	1,140	2,386
Total	2,495	3,487	5,982	3,077	4,735	7,812	13,794

Total White Male vs Total White Female
 $\chi^2 = 0.4327$ ($p > .001$)

Total Black Male vs Total Black Female
 $\chi^2 = 4.0085$ ($p > .001$)

Table 4
*Distribution of Blood Pressures by Age and Race,
 Newark, N.J., 1974-1976*

Age	Diastolic ≥ 95mm Hg				Systolic ≥ 160mm Hg			
	Black		White		Black		White	
	N	%	N	%	N	%	N	%
15 - 24	38/1645	2.3	20/442	4.5	14/1644	.9	8/442	1.8
25 - 34	186/1787	10.4	39/607	6.4	66/1787	3.7	26/607	4.3
35 - 44	310/1397	22.2	95/624	15.2	141/1397	10.1	42/624	6.7
45 - 54	356/1177	30.2	186/1059	17.6	250/1178	21.2	146/1059	13.8
55 and over	528/1806	29.3	562/3250	17.3	669/1806	37.0	1048/3250	32.2
Total	1418/7812	18.2	902/5982	15.1	1140/7812	14.6	1270/5982	21.2

Total Black vs Total White
 Diastolic ≥ 95mm Hg
 $\chi^2 = 16.1597$ ($p < .001$)

Total Black vs Total White
 Systolic ≥ 160mm Hg
 $\chi^2 = 71.8591$ ($p < .001$)

"Since June 1976, there have been some limited efforts to conduct screening, but there is no major city-wide program being carried out despite the evidence that hypertension is far more prevalent than any other treatable major disease in Newark."

studies and are also similar to those of Kidwell *et al.*, in a study of a Newark neighborhood health center.⁸ A large proportion of those screened (in this study over 70 percent) were lost to follow-up. A large portion of the follow-up letters sent were never returned. Many of those screened gave fictitious addresses. We found that many people enjoyed the free screening but indicated they did not want to have any further encounters with us. Our discouraging statistics in regard to follow-up do not vary greatly from those found in other urban centers such as Atlanta and Chicago where similar surveys have been conducted.⁹

Our results are not unexpected but it is particularly distressing that there are no major ongoing programs attempting to combat what is perhaps the major health problem in Newark today.

Initially our program was a collaborative effort among the medical school, New Jersey Regional Medical Program (RMP), and the City of Newark. After one year the City withdrew its funding and the medical school and RMP continued the efforts until RMP funding phased out in 1976. This caused the screening program to collapse.

Since June 1976, there have been some limited efforts to conduct screening, but there is no major city-wide program being carried out despite the evidence that hypertension is far more prevalent than any other treatable major disease in Newark. This seems unfortunate. Many millions are spent on the medical and social care for Newark residents suffering the medical consequences of hypertension, but the relatively small amount of money needed for comprehensive screening and follow-up for hypertensives that could prevent these complications is not available. It is true that patient compliance is often unsatisfactory and a variety of approaches

are needed to augment the efficacy of the follow-up once asymptomatic hypertension is detected.

If a major controllable disease in a community is not attacked adequately we believe there must be a restructuring of medical priorities. Such a restructuring becomes even more imperative when the financial resources for health care become increasingly restricted.

SUMMARY

Over a two-year period 13,912 self-selected Newark residents were initially screened for hypertension. Approximately 24 percent had pressures equal to or greater than 160 mm Hg systolic and/or 95mm Hg diastolic. Among blacks one in six aged 25 to 44, almost one in three aged 45 or older had a diastolic pressure of at least 95mm Hg. Despite these data there is no concerted effort in this city whose population is predominately black to attack what is clearly one of the most important medical abnormalities.

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Atrial Fibrillation in the Wolff-Parkinson- White Syndrome

JULIUS A. GUTMAN, M.D., and
JACOB I. HAFT, M.D., Newark*

Atrial fibrillation in patients with Wolff-Parkinson-White Syndrome (WPW) can be a life-threatening event because of extremely rapid heart rates. Three patients with atrial fibrillation and WPW are presented and the methods of diagnosis and current management are discussed.

Atrial fibrillation is usually an easily managed arrhythmia when it occurs in the common settings of rheumatic heart disease, chronic obstructive lung disease, or coronary artery disease. However, when it occurs in a patient with the Wolff-Parkinson-White syndrome (WPW), the ventricular response rate may be so rapid (200 to 300 beats per minute) that the patient may experience syncope, ventricular fibrillation, or sudden death. The electrocardiogram demonstrates a very rapid rhythm with wide QRS complexes that suggest the diagnosis of ventricular tachycardia. Moreover, digitalis, which is effective in slowing the ventricular response rate in patients without ventricular preexcitation, may accelerate the rate in patients with WPW. For these reasons it is of paramount importance to recognize that rapid atrial fibrillation may be a manifestation of WPW and to treat the patient appropriately.

During the past six months three patients with the Wolff-Parkinson-White syndrome who developed atrial fibrillation were admitted to St. Michael's Medical Center. It is the purpose of this communication to present the clinical findings and management of these patients and to discuss treatment of atrial fibrillation in patients with WPW.

Case #1—A 26-year-old male was admitted to St. Michael's Medical Center because of rapid heart action of seven hours' duration. The patient was entirely well until the day prior to admission at which time he developed palpitations and vomiting following an alcoholic binge. He slept

poorly and presented to the emergency ward of St. Michael's Medical Center because of persistent palpitations and nausea. He had no chest pain, dyspnea, or lightheadedness.

On further questioning the patient specifically denied previous palpitations, syncope, lightheadedness, chest pain, or exertional dyspnea. He was taking no medications and never had been hospitalized or had a previous electrocardiogram.

On physical examination he was a well-developed and well-nourished male. The apical pulse was 180 to 210 per minute and irregularly irregular; the blood pressure was 140/70, respiratory rate 16, and the temperature was 99 degrees F. The head, eyes, ears, nose, and throat were normal. The jugular venous pulse was not seen; the carotid pulse volume was diminished. Examination of the heart revealed the apex to be located within the midclavicular line. The first heart sound varied in intensity and the second heart sound was single. No murmur or gallop was heard. On abdominal examination there was slight epigastric tenderness but no organomegaly. The peripheral pulses were felt easily. The remainder of the physical examination was normal.

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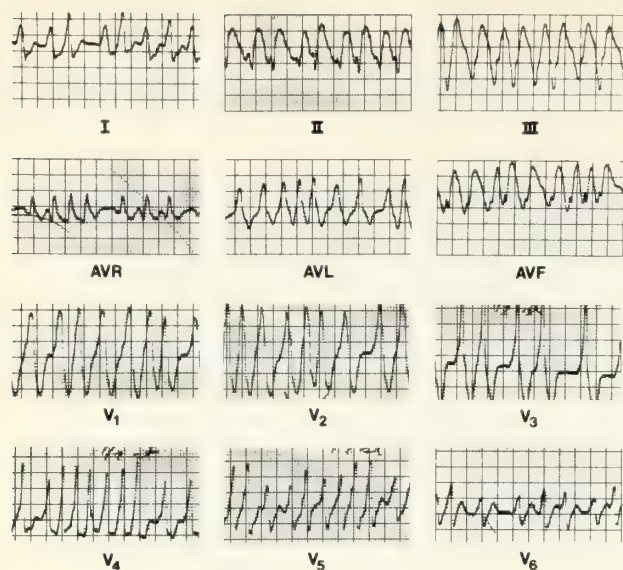


Figure 1—EKG of patient #1 demonstrating rapid ventricular response to atrial fibrillation.

The electrocardiogram (figure 1) showed atrial fibrillation with a rate of 240 to 280 per minute with QRS complexes of variable duration and form and non-specific ST-T abnormalities. CBC and electrolytes were normal. Portable chest x-ray demonstrated no abnormalities.

The patient was admitted to the coronary care unit with a tentative diagnosis of ventricular tachycardia. Lidocaine, 100 mg, was given intravenously without effect. Upon review of the rhythm strip, atrial fibrillation in the setting of WPW was suspected. Ouabain was given intravenously in a dose of 0.2 mg followed by 0.1 mg intravenously every hour. Because of the possibility of WPW the electrocardiogram was monitored carefully to determine that the heart rate did not increase. The patient did not develop chest pain and the blood pressure remained stable at 130 to 140 mm Hg systolic. Six hours after admission, after a total of 0.5 mg of ouabain the rate remained greater than 200 per minute. Wolff-Parkinson-White syndrome was considered more strongly but, before procainamide could be started, the patient converted to normal sinus rhythm at a rate of 78 per minute. Findings on the post conversion electrocardiogram (figure 2) included the short PR interval, wide QRS complex, and delta wave in leads II, III, AVL, AVF, V₁, V₂, V₃, V₄ and V₅ characteristic of the WPW syndrome. The patient was started on procainamide 375 mg orally every six hours. The arrhythmia did not recur.

On the fifth hospital day the patient underwent His bundle electrocardiography as previously described.^{1,2} A recording catheter was placed by percutaneous puncture of the right femoral vein across the tricuspid valve to record the His spike, and the second catheter was placed as a pacing electrode in the right atrium via antecubital vein cutdown. During the study the patient had normal atrial ventricular conduction without a delta wave. While in sinus rhythm the AH interval was normal (80m sec) and the HV interval was 35m sec which is normal. When the atrium was paced the patient immediately went into reciprocating tachycardia repeatedly. Pacing the atrium or right ventricle led to conversion to normal sinus rhythm on numerous occasions. Subsequently, during spontaneous atrial premature contractions (APC's) and paced premature atrial beats the QRS complexes had the characteristic form of WPW with a short

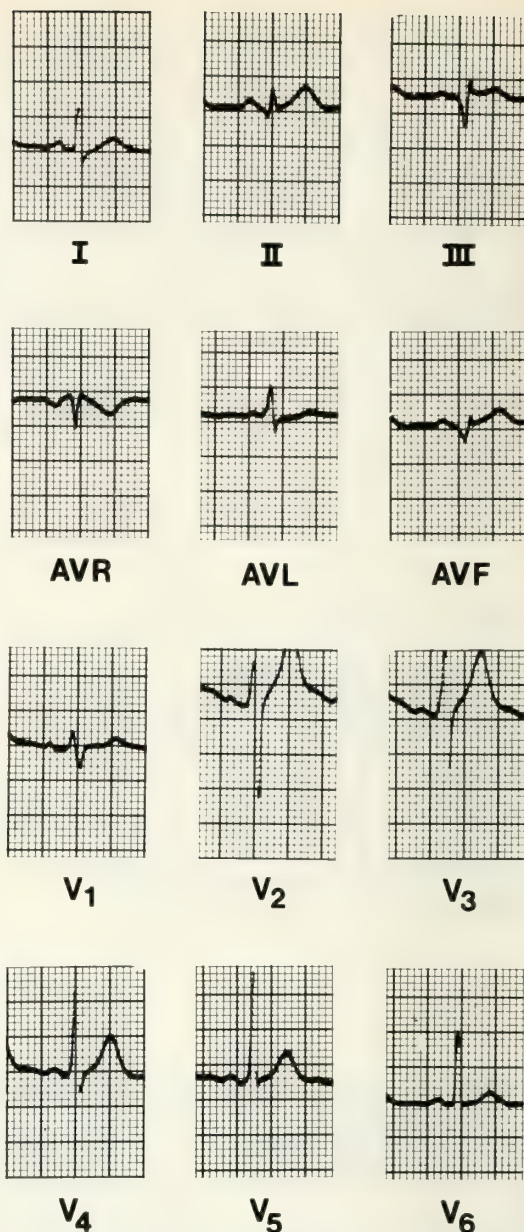


Figure 2—Post-conversion EKG of patient #1 showing a borderline short PR interval, delta wave (leads II, III, AVL, AVF, V₃₋₅ and prolonged QRS interval suggestive of WPW.

PR interval and with the His bundle deflection occurring after the onset of the QRS (figure 3).

The patient was maintained on procainamide 375 mg orally every six hours and digoxin 0.25 mg orally daily. He was discharged on the sixth hospital day without recurrence of his tachycardia.

Case #2—A 63-year-old male was admitted through the emergency ward for evaluation of palpitations of three days' duration. Five years prior to admission he was hospitalized for an episode of chest pain but evidence for a myocardial infarction was not found. Subsequently he was intermittently treated with thiazides for hypertension. One year prior to admission he began to experience episodes of dizziness, diaphoresis, and slight chest discomfort. They were short-lived with no relation to exertion but the symptoms became more frequent. Three days prior to admission he developed dizziness and diaphoresis which persisted until the time of admission.

The patient had a 40 pack-a-year history of cigarette

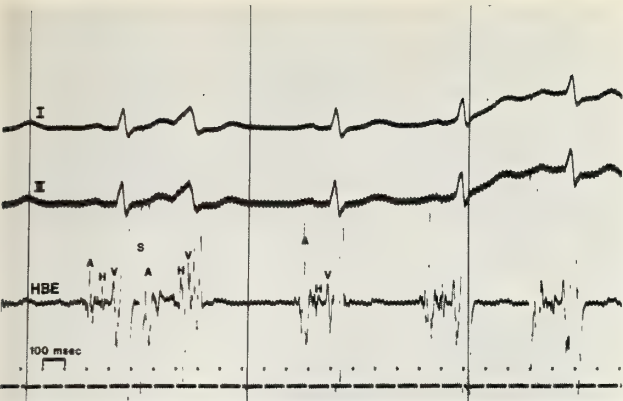


Figure 3—Intracardiac recording of patient #1. During normal sinus rhythm AV conduction appears normal without an obvious delta wave and with a normal PR and HV interval. The paced premature atrial beat has the characteristic delta wave of WPW conduction and the onset of the QRS following the atrial premature stimulus occurs well before the His spike, demonstrating accessory pathway conduction. I = EKG lead I; II = EKG lead II; HBE = His bundle electrogram; A = atrial depolarization; H = His bundle depolarization; S = atrial pacing stimulus; V = onset of ventricular depolarization.

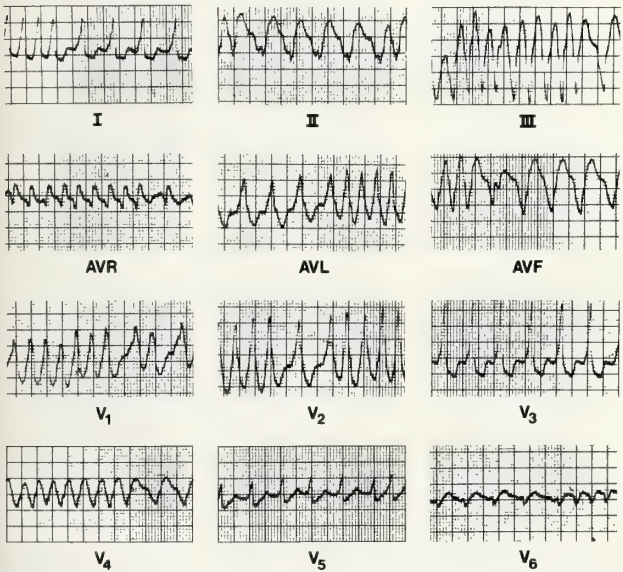


Figure 4—EKG of patient #2 demonstrating rapid ventricular response to atrial fibrillation.

smoking and had abused alcohol in the past. He denied previous syncope or known cardiac abnormalities. He was taking no medication at the time of admission.

On physical examination pulse was 180 to 210 per minute and irregularly irregular; the blood pressure was 140/80. The jugular venous pressure was normal. On cardiac examination the heart was not enlarged; the first heart sound varied in intensity and the second heart sound was single. No murmur or gallop was heard. Right upper quadrant tenderness without organomegaly was demonstrated. The peripheral pulses were felt easily.

The electrocardiogram demonstrated atrial fibrillation with a ventricular response rate of 250 to 300 per minute and ST-T abnormalities (figure 4). CBC and electrolytes were normal. The chest x-ray showed no abnormalities.

The patient was admitted to the coronary care unit where lidocaine, 100 mg, was given intravenously; the rhythm initially converted to sinus rhythm. Lidocaine infusion was continued at three mg per minute. The initial post-con-

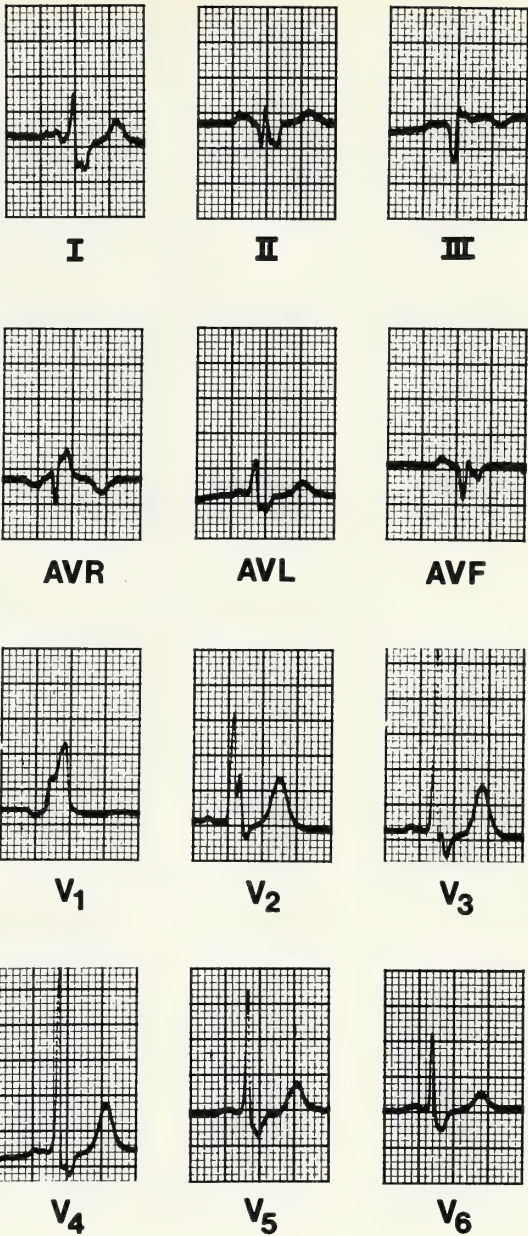


Figure 5—Post-conversion EKG of patient #2 demonstrating A RBBB pattern and the short PR interval and delta waves suggestive of WPW (leads I, II, III, AVF, V₁, V_{3,4}).

version electrocardiogram demonstrated sinus rhythm with WPW and RBBB (figure 5).

The patient's rhythm reverted to rapid atrial fibrillation six hours after initial conversion and thereafter did not respond to increasing amounts of intravenous lidocaine. Procainamide to a total of 1100 mg was given intravenously in 100 mg boluses over a period of one hour. This resulted in conversion to sinus rhythm at a rate of 70 per minute. Procainamide at a rate of four mg per minute intravenously was continued. The blood pressure remained stable at 130 mm Hg systolic throughout the period of intravenous procainamide infusion. Subsequently procainamide, 250 mg orally every four hours, and propranolol, 20 mg orally every four hours, were given. The heart remained in sinus rhythm without further episodes of atrial fibrillation.

The patient underwent His bundle electrocardiography on the eleventh hospital day. The AH interval was 85 m sec at a cycle length of 1180 m sec and the HQ interval (30 m sec) was abnormally short. Atrial pacing at progressively increasing

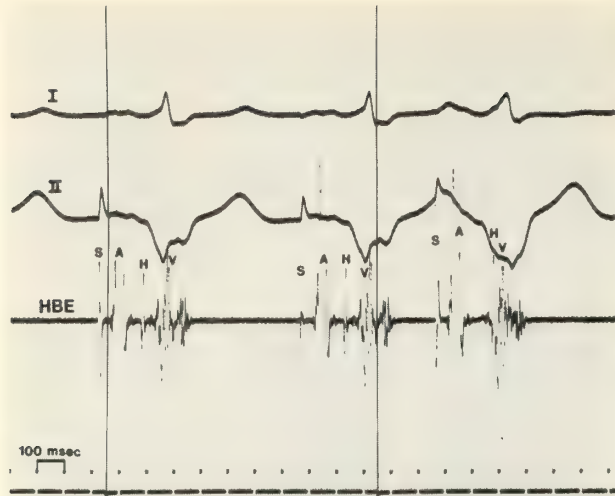


Figure 6—Intracardiac recording of patient #2. During atrial pacing with a basic cycle length of 760 m sec; a premature beat is introduced (beat 3). The onset of centricular activation (QRS) in lead II during the premature beat occurs prior to His depolarization. This finding documents conduction from the atria to the ventricles via an accessory bypass tract.

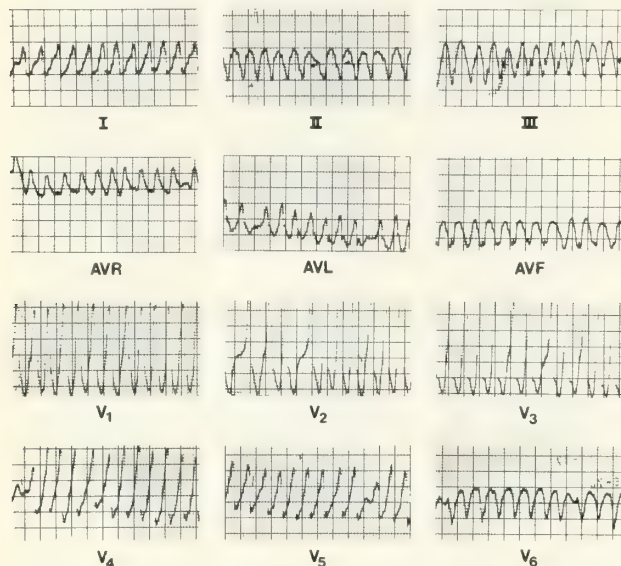


Figure 7—EKG of patient #3 demonstrating atrial fibrillation with a rapid ventricular response.

rates up to 150 per minute captured the ventricles with increasing aberrancy and progressive shortening of the HV interval. Atrial premature beats were induced by the extra-stimulus method described previously.³ At a pacing rate of 85 beats per minute, atrial extra-stimuli were conducted at a coupling interval that was progressively decreased from 400 msec to 300 msec. Progressive aberrancy of the QRS complex was demonstrated as the coupling interval was decreased. The PR interval remained constant and the His deflection moved into the QRS as more and more of the ventricular myocardium was depolarized via the accessory pathway (figure 6). Further decrease in the coupling interval below 300 m sec was not attempted in order to avoid initiation of sustained atrial fibrillation.

The patient was maintained on procainamide 250 mg orally every four hours and propranolol 20 mg orally every six hours and was discharged on the fourteenth hospital day without further episodes of atrial fibrillation.

Case #3—A 29-year-old male was admitted through the

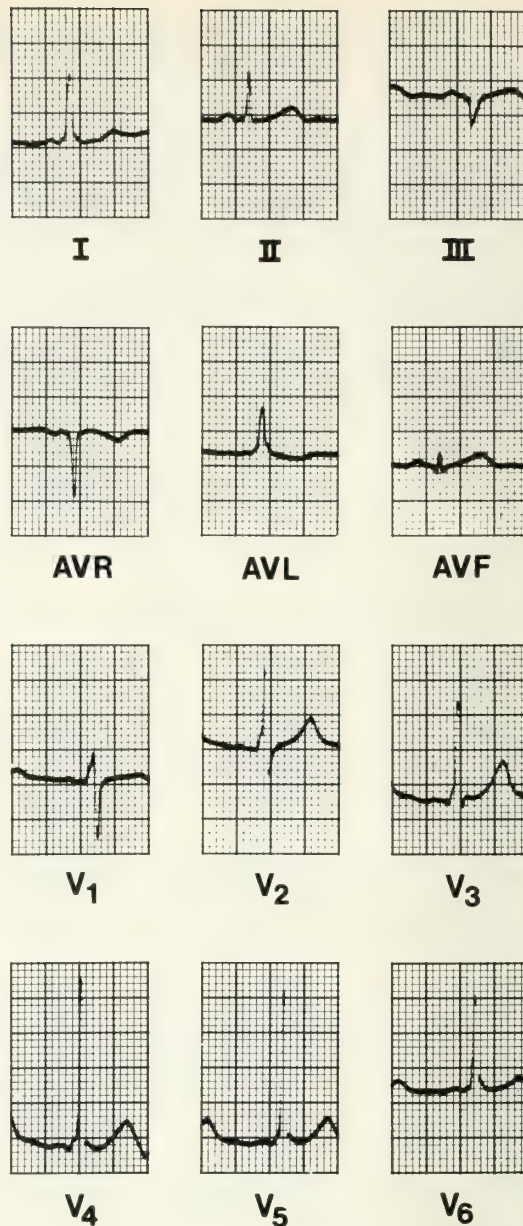


Figure 8—Post-conversion EKG of patient #3 demonstrating WPW.

emergency ward because of palpitations of two hours' duration. He previously had been well, without cardiac symptoms, until three hours prior to admission when he noted the abrupt onset of palpitation and lightheadedness. He had no associated dyspnea or chest pain. The patient recalled that nine years prior to admission a preemployment electrocardiogram had been interpreted as being consistent with the WPW syndrome. The patient specifically denied chest pain, shortness of breath, prior palpitations, or syncope. He was taking no medications.

Physical examination revealed a well-developed, well-nourished, pale, slightly diaphoretic male complaining only of palpitations. The apical pulse was 170 to 205 beats per minute and irregularly irregular. The blood pressure was 95/70 mm Hg. The neck veins were not seen. The lungs were clear and the heart was not enlarged. The first heart sound varied in intensity and the second heart sound was single. No murmur or gallop was heard. The abdomen was soft and without organomegaly. The peripheral pulses were felt easily.

The electrocardiogram demonstrated atrial fibrillation with a ventricular response rate of 280 to 300 per minute with

"Because the AV node rarely conducts at a rate faster than 220 beats per minute, any patient with atrial fibrillation and a very rapid ventricular response (greater than 220 per minute) should be suspected of having the WPW syndrome."

"DC-countershock is a very effective way to terminate atrial fibrillation and it is especially useful in ventricular preexcitation."

QRS complexes of variable duration and form with non-specific ST-T abnormalities (figure 7). CBC, electrolytes, and subsequently SMA-12 and chest x-rays were normal.

The patient was admitted to the coronary care unit. Following premedication with intravenous diazepam, DC-countershock at 100 watt seconds terminated the arrhythmia after countershock at 50 watt seconds was ineffective. The post-conversion electrocardiogram demonstrated the typical features of WPW (figure 8). Intravenous procainamide was immediately given and the patient subsequently was maintained on procainamide and propranolol orally without subsequent arrhythmia.

The patient was discharged on the sixth hospital day on procainamide 375 mg orally every six hours and propranolol 10 mg orally three times daily. He has had no recurrence of his presenting symptoms to date.

DISCUSSION

When atrial fibrillation develops in a patient without ventricular preexcitation the AV node usually protects against a rapid ventricular response by blocking most of the 300 to 600 impulses per minute that are initiated in the atria. However, in the WPW syndrome, the electrophysiologic pathway that bypasses the AV node and directly links the atria and ventricles (electrophysiologic accessory pathway) frequently can conduct at rates up to 300 per minute or more. Because the AV node rarely conducts at a rate faster than 220 beats per minute, any patient with atrial fibrillation and a very rapid ventricular response (greater than 220 per minute) should be suspected of having the WPW syndrome.

In addition to the rate, the electrocardiogram usually shows findings that suggest the possibility of WPW. The QRS complexes are wide and bizarre and vary from beat to beat as conduction occurs to varying degrees through the normal and the accessory pathway. The widest complexes are due to conduction exclusively via the accessory pathway; some of the QRS complexes which are narrower are fusion beats between conduction via the normal and the accessory routes, and may show a clearly documented delta wave and, rarely, normal QRS complexes may be seen. The rhythm may be difficult to distinguish from ventricular tachycardia. However, atrial fibrillation in patients with WPW tends to be more irregular than ventricular tachycardia, which is usually fairly regular. The form of the QRS varies, whereas the QRS is fairly uniform in most cases of ventricular tachycardia. Moreover patients with ventricular tachycardia at these rapid rates (> 200/min) usually are hypotensive and appear moribund while patients with a rapid ventricular response due to atrial fibrillation and WPW are usually surprisingly well, though occasionally they may show evidence of compromise of cardiac function.

The treatment of rapid atrial fibrillation in the setting of

ventricular preexcitation may be approached in several ways. DC-countershock is a very effective way to terminate atrial fibrillation and is especially useful in ventricular preexcitation. Should any signs of hypoperfusion be present (hypotension, clouded sensorium, and so on) cardioversion is the treatment of choice. Patient #3 underwent DC-cardioversion because his blood pressure on presentation to the emergency ward was less than 100 mm Hg systolic and his pallor and diaphoresis suggested a compromised cardiac output. The only relative contraindication is prior digitalis intoxication in which case DC-cardioversion may induce intractable ventricular fibrillation and death. The disadvantage of DC-countershock is that although the arrhythmia will be terminated, reversion back to atrial fibrillation is a distinct possibility. This may be prevented by administration of a variety of antiarrhythmic agents before or immediately after cardioversion. This is illustrated by patient three who was cardioverted successfully to sinus rhythm electrically and maintained initially on procainamide given intravenously and then orally on a long-term basis.

Digitalis preparations, although considered to be dangerous now, have been documented in the past either to slow the ventricular response rate or to convert atrial fibrillation to sinus rhythm in some patients with WPW.⁴ This is illustrated by patient #1 in whom digitalization with ouabain (total of 0.5 mg intravenously) converted with rhythm to a sinus mechanism within four hours. In some patients with WPW and atrial fibrillation, digitalis has been found to dangerously increase the ventricular response rate, and occasionally to cause sudden death. The explanation for this phenomenon lies in the differential electrophysiologic effects of digitalis on accessory pathway conduction and AV nodal conduction. AV nodal conduction is predictably slowed by digitalis, because of increased conduction time and prolonged refractory period, and the resulting frequency of impulses conducted through the node to the ventricles will be decreased. The effect of digitalis on accessory pathway conduction may be exactly the opposite. Thus, digitalis may accelerate conduction through the accessory pathway by decreasing conduction time and shortening the refractory period of the accessory pathway, thereby increasing the frequency of impulses conducted to the ventricular myocardium. In a recent electrophysiologic study this detrimental effect was demonstrated in six of 21 patients.⁵ There is no way, a priori, of predicting which patients will benefit and which patients will be harmed by digitalis. For this reason digitalis usually is not recommended for treatment of atrial fibrillation in patients with WPW. If it is used in a patient with atrial fibrillation and a very rapid rate (in whom WPW should be suspected) the patient must be monitored meticulously and if any evidence of increase in ventricular rate is noted or if the rate does not decrease

"In some patients with WPW and atrial fibrillation, digitalis has been found to dangerously increase the ventricular response rate, and occasionally to cause sudden death."

"Presently the drug which is most easily available that is rapidly effective is procainamide, which slows conduction through both the AV node and the accessory pathway."

significantly, WPW should be strongly suspected and further administration of digitalis preparations must be discontinued and other modes of therapy must be considered.

A number of antiarrhythmic drugs have been documented to slow conduction through the accessory pathway and terminate atrial fibrillation or at least slow the ventricular response. Procainamide, lidocaine, quinidine, verapamil, aprindine, and to a lesser extent, propranolol, all have been used successfully. Lidocaine has been documented to be effective when given in an intravenous bolus of 50 to 100 mg and is quite safe and rapidly acting. Although it was ineffective in one of two patients presented here and only transiently effective in the other patient, its convenience and safety make it a worthwhile drug to try.

Presently the drug which is most easily available that is rapidly effective is procainamide, which slows conduction through both the AV node and the accessory pathway. Given intravenously it terminated the arrhythmia in patient #2 although a relatively large amount (1100 mg) was necessary. The major disadvantage of this agent is its potential for causing hypotension, especially in a patient in whom the rapid ventricular rate may already have caused some degree of hemodynamic compromise.

Although verapamil and aprindine are not readily available in this country, they have been used extensively in Europe and South America, and are reported to be quite effective.^{6,7} When they gain FDA approval for use in the United States, these drugs may supercede the currently available antiarrhythmics in the treatment of atrial fibrillation in WPW.

When drugs fail to prevent recurrences of any life-threatening supraventricular arrhythmia in patients with Wolff-Parkinson-White syndrome and especially if atrial fibrilla-

tion with a rapid ventricular response recurs often, consideration should be given to surgical interruption of the accessory pathway. Presently only a few centers in the United States commonly are performing the operation that includes, first, anatomically locating the accessory pathway by open chest epicardial mapping, and then successfully dividing it to abolish the abnormal AV conduction pathways. The greatest experience has been at Duke in North Carolina,⁸ where a relatively large number of patients have undergone successful surgery. Prior to consideration for surgery, electrophysiologic evaluation by standard His bundle techniques and drug trials should be pursued.

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Non-Acidotic Acetonemia: A Syndrome Due to Isopropyl Alcohol Intoxication

SHASHI K. AGARWAL, M.D., Newark*

Acetonemia due to isopropanol intoxication may be more common than generally is appreciated. Suspicion of this etiology may be aroused by the absence of an associated acidosis. Early recognition of this syndrome is important since its treatment differs significantly from that of other causes of acetonemia.

Significant acetonemia and acetonuria usually are seen with diabetes mellitus.¹ Acetonemia also may occur with ethyl alcoholism,² starvation,³ and cyanide poisoning.⁴ In all of these conditions there is usually an associated acidosis due to the simultaneous presence of acetoacetic and hydroxybutyric acids. Although isopropyl alcohol intoxication is not uncommon⁵, its presentation as a nonacidotic acetonemic syndrome is not well known.⁶ In the following two cases of isopropyl alcohol intoxication high levels of serum acetone were associated with minimal deviations from the normal values of blood glucose, blood pH, serum bicarbonate, and anion gap. The purpose of this communication is to emphasize the diagnostic significance of this unusual constellation of laboratory results.

CASE #1:

A 19-year-old male was admitted to the medical services of Bergen Pines County Hospital because of drowsiness. He had arrested hydrocephalus with mental retardation and was treated with thioridazine (Mellaril®) 150 mg orally daily at bedtime. On the morning of admission, he was noticed to be drinking large quantities of milk and behaving in a bizarre manner. Subsequently he became drowsy and was brought to the hospital. There was no history of head injury, diabetes, convulsions, fever, or starvation. There was no definite history of any drug overdose. Other medical, personal, and family history was unremarkable. On examination, the patient was drowsy. Temperature was 98.8° F rectally, BP

100/70 mm Hg in the supine position with a regular pulse of 88 per minute, and the respirations were unlabored at a rate of 18 per minute. There was macrocephaly; pupils measured four mm and reacted well to light. There was a high arched palate and acneiform lesions of the face. Other examination was essentially within normal limits.

Laboratory investigations revealed a blood glucose of 100 mg/dl, BUN 19 mg/dl, Na 146 Meq/L, K 3.9 Meq/dl, Cl 105 Meq/L, CO₂ 28 Meq/L and an anion gap of 13. Arterial blood gases showed a pH of 7.44, PCO₂ 37.4, TCO₂ 26, PO₂ 82.4 and actual bicarbonate of 24.9. Urine had a pH of 7, a trace of acetone but no glucose. Serum acetone was 30mg/dl. SMA 12, CBC, PT, PTT, and chest roentgenograms were within normal limits. An electrocardiogram revealed sinus tachycardia. Blood toxicology failed to reveal any drugs besides acetone and urine showed traces of thioridazine. A gastric lavage was done and the returns showed isopropyl alcohol and acetone. An analysis of the milk the patient had been drinking revealed isopropyl alcohol. He apparently had mixed rubbing alcohol with milk and ingested it.

The patient was admitted to the Intensive Care Unit and forced water diuresis was given. A continuous gastric lavage was instituted and antacids were given hourly. After about seven hours the patient was noted to be somnolent so a spinal

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puncture was done. The cerebrospinal fluid was clear with a glucose of 95 mg/dl, protein of 49 mg/dl, and acetone of 20 mg/dl. No cells or bacteria were noted. A simultaneous blood chemistry showed a glucose of 133 mg/dl, BUN 14 mg/dl, Na 144 Meq/L, K 3.9 Meq/L, Cl 99 Meq/L, CO₂ 29 Meq/L, serum acetone 130 mg/dl and an anion gap of 16. The blood pressure and other vital signs were stable. The treatment modalities were not changed. The following day, approximately 20 hours after admission, the patient was more responsive. Vital signs were unchanged and blood chemistry revealed a serum acetone of 100 mg/dl. Blood glucose was 107 mg/dl, BUN 5 mg/dl, Na 140 Meq/L, K 4.0 Meq/L, Cl 101 Meq/L, CO₂ 27 Meq/L, and an anion gap of 12. On the third day following admission, the patient was fully alert and blood revealed a serum acetone of 40 mg/dl. Hepatic and renal function tests remained normal. On the fifth day of hospitalization, the blood and urine were negative for acetone. Blood glucose was 95 mg/dl, BUN 13 mg/dl, Na 143 Meq/L, K 4.2 Meq/L, Cl 102 Meq/L, CO₂ 29 Meq/L and an anion gap of 12. The patient was discharged with recommendations for psychiatric follow-up.

CASE- #2

A 53-year-old male was admitted to Bergen Pines County Hospital with complaints of abdominal pain. He was known to suffer from chronic alcoholism and had been drinking alcoholic beverages until the day of admission. The pain was epigastric and was associated with frequent vomiting productive of small amounts of nonbloody gastric content. There was no history of constipation, diarrhea, gallstones, or peptic ulcer. He was on a restricted diet for diabetes mellitus and essential hypertension and his medication included phenytoin 300 mg per day for a seizure disorder of many years' duration. Other medical, personal, and family history was unremarkable.

On examination, he was drowsy but oriented. Body temperature was 98°F rectally, BP was 160/100, pulse 100 per minute and regular, and respiratory rate was 20 per minute. Except for epigastric tenderness, the physical examination was otherwise unremarkable. Laboratory investigations revealed a normal blood count and chest roentgenogram. Blood glucose was 155 mg/dl, BUN 12 mg/dl, Na 138 Meq/L, K 3.5 Meq/L, Cl 99 Meq/L, CO₂ 23 Meq/L, and an anion gap of 16.5. Serum amylase was 117 Somogyi units, CPK 66, and serum acetone 250 mg/dl. Arterial blood gases showed a pH of 7.53, PCO₂ 25, TCO₂ 19, and actual bicarbonate 18. The electrocardiogram revealed sinus tachycardia and nonspecific ST-T wave changes; abdominal roentgenogram demonstrated small bowel ileus.

The high levels of acetone without an associated acidosis aroused the suspicion of isopropanol poisoning. A gastric lavage was done and the returns showed isopropanol. A blood specimen revealed isopropanol at a level of 20 mg/dl.

The patient was treated in the intensive care unit. In-

"The symptoms of isopropyl alcohol toxicity may mimic those of ethanol ingestion. It is a potent central nervous system (CNS) depressant and death may occur due to respiratory arrest in deep coma."

travenous fluids were administered and hemodialysis performed. The following day the patient was more alert. Laboratory investigations showed a blood glucose 203 mg/dl, BUN 12 mg/dl, Na 138 Meq/L, K 3.2 Meq/L, Cl 100 Meq/L, CO₂ 23 Meq/L, and an anion gap of 15. Serum acetone was 60 mg/dl while no isopropanol could be detected in the blood. The patient continued to improve and the acetone gradually disappeared from the serum. The patient was discharged on the seventh day of hospitalization.

DISCUSSION

Isopropyl alcohol is an important industrial solvent and disinfectant. In the home it is found as a component of numerous commercial products such as rubbing alcohol, skin lotions, hair tonics, and antifreeze preparations and is thus readily accessible for abuse. It is also an ingredient of illegal alcoholic beverages.

It is more toxic than ethyl alcohol and is known to cause toxicity after oral ingestion,⁵ rectal administration,⁷ or vapor inhalation.⁸ No appreciable absorption occurs after dermal application. The symptoms of isopropyl alcohol toxicity may mimic those of ethanol ingestion. It is a potent central nervous system (CNS) depressant and death may occur due to respiratory arrest in deep coma.⁴ Cardiac toxicity may be manifested as severe hypotension, dysrhythmias and even cardiac arrest. Hepatic, renal, and muscle toxicity also have been reported.⁹ Except for an initial CNS depression, both of my patients had a relatively benign course.

A part of the absorbed isopropyl alcohol is excreted unchanged by the lungs and the kidneys. Excretion is also known to occur in the saliva and gastric juice.¹⁰ For this reason prolonged gastric lavage was carried out in my patients. Although forced water diuresis was instituted in the first patient, its effects on increasing renal excretion of isopropyl alcohol and acetone are insignificant.¹¹

A major amount of isopropyl alcohol is oxidized to acetone by liver dehydrogenase.¹² This acetone spills in the urine and is detected on the breath. Insignificant quantities of formic acid, acetoacetic acid and beta-hydroxybutyric acid may be produced rarely.¹³ As a result, acidosis usually does not occur and the serum bicarbonate and the blood pH remain normal. This was seen repeatedly in my patients. Since its metabolic pathways differ from those of glucose and ethyl alcohol, administration of insulin or glucose and insulin does not accelerate its catabolism.¹¹ Acetone is gradually cleared from the body; it took five days in the first patient.

Elevated CSF protein has been reported before¹⁴ and was seen in the first case. Although the CSF acetone was 20 mg/dl, a repeat spinal tap was not done.

CONCLUSION

This unusual constellation of laboratory results, especially in a patient with altered mental status, should arouse the

"A major amount of isopropyl alcohol is oxidized to acetone by liver dehydrogenase. This acetone spills in the urine and is detected on the breath."

suspicion of isopropyl alcohol intoxication. Since fatalities do occur,⁸ early recognition of this entity may save lives as this drug can be removed by peritoneal dialysis¹⁵ or hemodialysis.¹⁶ Further, confusion with diabetic ketoacidosis and inappropriate treatment with insulin will be prevented.

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Severe Lactic Acidosis in Reticulum Cell Sarcoma

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Severe intractable lactic acidosis, with associated hypoglycemia and hyponatremia, was present in a patient with a huge, relatively localized reticulum cell sarcoma. The metabolic disorder was resistant to treatment. A review of the literature for the last ten years revealed only one similar case.

Lactic acidosis in various disease states has been described since 1955. McKenney and Rundles first described this pathologic condition in leukemic human leukocytes.¹ Field *et al.* described 13 such patients with lactic acidosis.^{2,3} Some authors hypothesized that the leukemic cell becomes hypoxic, and produces lactate via an anaerobic pathway. Kachel was apparently the first to report the occurrence of lactic acidosis in metastatic reticulum cell sarcoma.⁴

Hypoglycemia of neoplastic origin, which was also present in our case, has been reported in extra-pancreatic tumors of mesodermal origin usually located in the thoracic or retroperitoneal area. The cause of hypoglycemia varies and may be complex. More than one mechanism may coexist in the same individual.

In our patient, hyponatremia, resistant to treatment, was also manifest.

CASE REPORT

The patient was a 64-year-old male whose present illness began 17 weeks before admission to Middlesex General Hospital, when he noticed a palpable mass in his left flank. He felt weak and chronically fatigued. He also complained of a weight loss, recurrent fever, and inspiratory left chest pain of recent origin.

Physical examination revealed a chronically ill-appearing, pale male. Vital signs were all within normal limits. Breath

sounds were diminished at the left lung base. Anterior abdominal examination was negative but a large ill-defined, tender, fixed, rounded mass was palpated in, and bulged from the left flank from just below the postero-lateral costal margin to the iliac crest. Upper gastrointestinal x-ray study and barium enema were within normal limits. Intravenous pyelography revealed a mild hydronephrosis of the left kidney, with rotation of the renal pelvis. An ultrasonic B-scan detected a mass which was not separable from the kidney. A moderate effusion was seen in the left pleural cavity. Admission laboratory studies revealed a hemoglobin of 11.3 G/dl, with a hematocrit of 34 percent. Other tests were within normal limits.

On the day after admission, the patient appeared in marked distress with a pulse rate of 130 per minute and a respiratory rate of 48. Arterial blood gases at this time revealed a pH of 7.34, PaCO₂ of 19mmHg, CO₂7mEq/L, PaO₂93mmHg, O₂ saturation 96.5 percent, HCO₃ 9.3mEq/L. The serum lactate level was 13.0mEq/L. (Normal 0.5-2.2). Serum glucose was 16mg/dl. The patient's clinical signs and symptoms improved after several infusions of sodium

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bicarbonate totaling 200mEq over a 12-hour period. This returned the arterial blood gases to a normal range.

On the fourth hospital day, the patient's clinical condition again worsened with deterioration in electrolyte and acid-base balance. The sodium was 129mEq/L., chlorides 91, and CO₂ 12.

An arterial blood gas study showed the pH to be 7.38, PaCO₂20mmHg, and bicarbonate level 10.5mEq/L. This time the patient received 673mEq of sodium (including 450mEq as NaHCO₃ over 24 hours at which time a repeat serum sodium was 128mEq/L. At this time, the total 24-hour urine volume was 1250cc and urine electrolytes were Na 74mEq/L, K 45, Cl 95. The serum LDH was 2080 units and serum lactate 11.6mEq/L. A chest film showed an increase in his pleural effusion, which was aspirated.

An incisional biopsy and frozen section of the flank mass was carried out under local anesthesia. The surgical specimen showed invasion of skeletal muscle and fat by a relatively uniform cellular population of malignant cells. Both imprint preparations and direct histologic examination supported the diagnosis of reticulum cell sarcoma, and this was further confirmed by special stains for reticulum fibers. A study of the peripheral blood smear and the pleural effusion disclosed similar atypical and neoplastic cells, characterized by their large dimensions and prominent, often multiple nucleoli.

The patient was scheduled for chemotherapy, but expired on the ninth hospital day with right lower lobe pneumonia, septic shock, and possible disseminated intravascular coagulopathy. He had shown no evidence of hypoxia or hypercarbia before he developed the pneumonia, nor was keto-acidosis detected at any point in his hospital course.

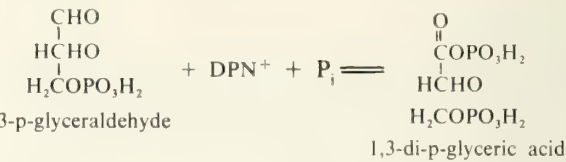
Postmortem examination revealed a large left retroperitoneal tumor mass, invading the left adrenal gland and left kidney, with entrapment of left ureter and descending colon. There was extension to the vertebral column and left seventh and eighth ribs posteriorly. The pancreas was invaded by direct extension, but the liver was not involved. Chylous ascites and a serous pleural effusion were present, along with extensive bronchopneumonia, pulmonary edema, and congestion.

DISCUSSION

It is known that normal leukocytes of the myeloid series possess a high rate of aerobic glycolysis. Leukocytes from patients with leukemia do not have this capacity.¹ Incubation of such cells in an atmosphere of nitrogen increased the yield of lactic acid. It is also known that leukemic leukocytes have less glyoxalase activity than do normal leukocytes. Field showed that, in vitro, acid production by leukemic leukocytes was low in the presence of normal oxygen tension, but increased 8 to 12 fold with hypoxia.^{2,3} If leukemic cells become hypoxic due to crowding in organs, lactic acid production from this source can make up the major portion of total body lactate turnover.

The pathogenesis of the lactic acidosis seen in this patient can be hypothesized as follows:

This patient had a high serum lactic acid dehydrogenase (2580 U.), and a large hypoxic area consisting of tumor and heavily infiltrated muscle. In following the aerobic Embden-Meyerhof glycolysis pathway, DPN⁺ needs to be reduced to DPNH⁺ + H⁺ when 3-phosphoglyceraldehyde is oxidized to 1,3-diphosphoglyceric acid.



The action of LDH prevents DPN⁺ reduction and leads the chemical reaction along an anaerobic pathway to lactic acid formation. The equilibrium position of the LDH reaction, like that of all reactions involving an alcohol and DPN, strongly favors formation of lactic acid rather than its oxidation.^{4,6} Hence, glycolysis proceeds smoothly with the next accumulation of two molecules of lactic acid per mol of glucose. This patient did not have metastasis to the liver, in which organ most lactic acid is oxidized to pyruvate for further metabolism. All liver function tests were within normal limits, which seems to rule out lactic accumulation secondary to hepatic failure.

With regard to the possible causes of hypoglycemia, Perkoff and Simon's study revealed that their tumor contained no insulin, but did contain a heat-stable, non-dialyzable factor with stimulated simultaneous glucose uptake and glycogenolysis.⁷ Insulin-like activity has been described in some fibrosarcomas. Another explanation was suggested by Jakob and others.⁸ A blocking of hepatic glucose release was found to be the main cause of hypoglycemia in patients with large tumors of non-endocrine origin. The deficiency of hepatic glucogenesis may have been a factor in the hypoglycemia seen in our patient, although this remains speculative. The activity of one or more regulatory enzymes in the pathway from pyruvate to glucose may have become reduced by a tumor-derived substance. Metabolites of tryptophane were thought to be possible causes of hypoglycemia in certain disease states. Silbert and his group recently reported an interesting patient with benign mesothelioma who had a low serum insulin and a low glucose utilization rate.⁹ Splanchnic glucose uptake was decreased, which was the principal cause of hypoglycemia, and was at least partly due to deficient glucagon secretion. Their tumor produced an insulin-like substance primarily and did not affect the liver or the alpha-cells of pancreatic islets. In their case, the non-suppressible insulin-like activity (NSILA-s) of the serum was not elevated. In our patient, the cause of hypoglycemia is uncertain. More than 80 percent of the pancreas was invaded by tumor, yet hypoglycemia

“A blocking of hepatic glucose release was found to be the main cause of hypoglycemia in patients with large tumors of non-endocrine origin.”

“In our patient, the cause of hypoglycemia is uncertain. More than 80 percent of the pancreas was invaded by tumor, yet hypoglycemia developed.”

developed. The effect of glucose infusion on the tumor cell and the lactic acidosis is controversial.

This patient's hyponatremia could not be improved by sodium administration. Even administration of 673mEq. of sodium over 24 hours did not increase greatly the serum sodium concentration despite the absence of significant sodium loss in the urine. The loss of sodium into the tumor itself might be a factor in lactic acidosis (edematous loose stroma was present on microscopic examination), since sodium ion has been transported into cells because of sodium pump deficiency.

SUMMARY

A patient with proved extensive reticulum cell sarcoma developed resistant lactic acidosis, hypoglycemia, and hyponatremia. Although the cause of these metabolic aberrations is not clear, the hypoglycemia and lactic acidosis are believed to have resulted from hypoxia within the large mass of tumor, excessive metabolism of circulating blood glucose, and the consequent production via anaerobic pathways of excessive lactic acid.

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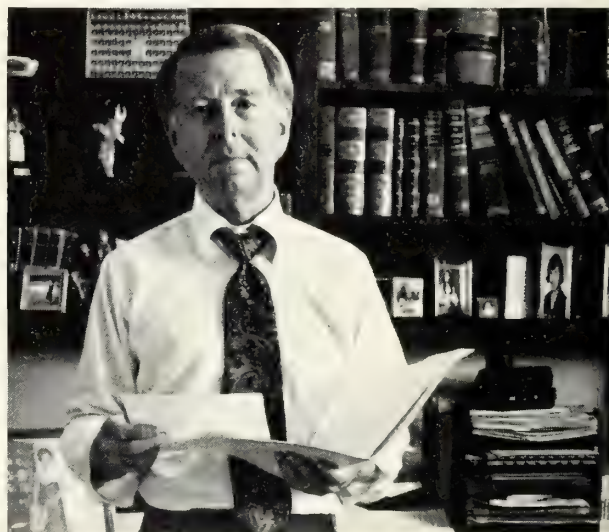
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The Relationship of Diet to Intestinal Gas

ALLEN S. LEVINE, Ph.D., Minneapolis

With the treatise "The Flatuositates," Hippocrates initiated a discussion about the relationship of diet to intestinal gas which continues today. While individuals may be confident that their gas is caused by one or more foods ranging from abalone to zweibach, there have been few scientific papers which document the causes of intestinal gas.

COMPOSITION AND VOLUME

Collection of rectal gas by rectal tube has indicated that the normal individual excretes approximately 400-1200 ml of gas per day. However, the amount of gas collected via rectal tube does not necessarily reflect the volume of gas present in the bowel. A person may expel a given amount of gas shortly after it was produced and therefore gas would not accumulate. Thus, this individual would not experience abdominal distress. In contrast, another individual may produce relatively small amounts of gas which accumulate in his intestinal tract and thus cause him pain and distention.

Determining the composition of gas in the bowel allows one to speculate about the source of the gas and thus evaluate the relationship of diet to gas production. The volume and composition of intestinal gas has been determined by flushing all the gas in the bowel with argon and collecting this effluent from the rectum. It has been shown that more than 99 percent of intestinal gas is comprised of nitrogen, oxygen, hydrogen, methane and carbon dioxide.

SOURCES OF INTESTINAL GAS

Some physicians and patients believe that the source of virtually all intestinal gas is swallowed air. However, since hydrogen, methane and carbon dioxide are not present in an appreciable concentration in the atmosphere, the presence of these gases in the intestinal tract could not be due to swallowed air. In addition, these gases are present in much greater concentration in the lumen of the bowel than in the blood, indicating that these gases could not have passed from the blood into the lumen. Nevertheless, in some people, hydrogen, methane and carbon dioxide comprise the bulk of the gas present in the bowel.

What, then, is the source of these gases? It has been shown that newborn infants and germ-free rats do not produce hydrogen or methane. However, after inoculation with bacteria, hydrogen and methane production begins. Thus, all hydrogen and methane found in the gastrointestinal tract must result from bacterial metabolism.

HYDROGEN

Important to the understanding of the relationship of diet to intestinal gas is the observation that hydrogen is produced

almost entirely in the colon, with the rate of production being dependent on the presence in the colon of adequate fermentation substrate. Fasting normal subjects produce negligible amounts of hydrogen. However, the ingestion of a nonabsorbable carbohydrate (such as lactulose) provides the colonic bacteria with a fermentable substrate which results in a marked increase in hydrogen production. Certain vegetables such as navy beans and soy beans contain non-absorbable carbohydrates which have been identified as the oligosaccharides, raffinose and stachyose. The human intestinal tract does not contain the necessary enzymes to split these oligosaccharides into simple sugars. Only simple sugars are absorbed by the gastrointestinal tract. Following the ingestion of beans, indigestible oligosaccharides pass through the small bowel and enter the colon where bacteria readily can utilize the carbohydrate as fermentation substrates and produce hydrogen. Steggerda measured the amount of hydrogen passed per rectum on a basal diet and on a diet in which 57 percent of the calories were provided by pork and beans. The average volume of hydrogen passed per hour increased from 3 to 19 ml when the subject changed from the basal to the pork and bean diet.

It is also apparent that people with gastrointestinal disease, such as celiac sprue, may complain of excessive gas. They malabsorb carbohydrates which normally are absorbed, thus yielding a large quantity of fermentable substrate for colonic bacteria. Another common example of malabsorption is individuals with lactase deficiency, a condition prevalent in at least 70 percent of the world's adults. These individuals lack the enzyme lactase which is needed to split lactose into its simple sugars and thus lactose reaches the colon where bacteria ferment it, producing large quantities of hydrogen.

Calloway's observation that hydrogen (and methane) are absorbed into the blood draining the large intestine and are then carried to the lungs where they are excreted in expired air, markedly simplifies the measurement of hydrogen (and methane) present in the gut. Thus, breath hydrogen has been substituted for the measurement of gut hydrogen production, providing a simple measurement of carbohydrate malabsorption. If carbohydrate is malabsorbed in the small bowel and passes into the colon, colonic production of hydrogen increases and is readily detected by an increase in excretion of hydrogen in the breath.

*Reprinted with permission of *Contemporary Nutrition* 3:7 (July 1979), a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Levine is affiliated with the Veterans Administration Medical Center, Department of Medicine, in Minneapolis, and is a lecturer in the Departments of Medicine and Nutrition at the University of Minnesota at St. Paul and Minneapolis.

One interesting feature of bacterial metabolism of hydrogen is that intestinal bacteria not only produce hydrogen but also consume hydrogen. Thus, the standard measurement of hydrogen production is actually a measurement of the net result of hydrogen production and consumption in the bowel. If the bacterial population of some individuals consumed hydrogen far more rapidly than other bacteria-produced hydrogen, it would appear that no hydrogen was produced.

METHANE

Methane, which is also a product of bacterial metabolism, is produced by only one out of three individuals. This tendency to produce methane (or not produce) is familial. For example, siblings of methane producers have an 84 percent incidence of methane production while siblings of non-methane producers have only an 18 percent incidence. This familial tendency to produce methane appears to be environmental rather than hereditary since 93 percent of an institutionalized group of young mentally retarded subjects who had been living in close proximity for a long period were methane producers. In addition, methane production does not seem to be related to diet since there is no correlation between the methane-producing status of husbands and wives.

CARBON DIOXIDE

Carbon dioxide, another nonatmospheric gas present in the bowel, has several possible sources. As is true for hydrogen, carbon dioxide can result from bacterial fermentation in the bowel. Such bacterial fermentation results in the production of much larger quantities of carbon dioxide than hydrogen. For example, in Steggerda's study in which subjects ingested a diet containing 57 percent of the calories in the form of pork and beans, the average quantity of carbon dioxide passed per hour was 89 ml compared with only 19 ml per hour of hydrogen.

Carbon dioxide theoretically also may be produced as a result of an interaction between acid and bicarbonate which releases 22.4 ml of carbon dioxide for each mEq of bicarbonate. The acid for this reaction may be supplied by hydrochloric acid from the stomach or by fatty acids released during the digestion of fats. Thus, based on the theoretical hydrogen ion availability, up to 4000 ml of carbon dioxide could be liberated from a normal-sized meal. Actual measurements of the amount of carbon dioxide released during meals have not been made. However, it has been shown that more than 75 percent of the gas in the duodenum of dogs, following a meal, was carbon dioxide. In any event, the significance of this gas as a cause of abdominal distress must remain speculative until the carbon dioxide which accumulates in the intestinal tract is measured.

OXYGEN AND NITROGEN

Although oxygen comprises about 21 percent of the atmosphere, it is present in an extremely low concentration in the colon, presumably as a result of the rapid utilization of oxygen by certain colonic bacteria.

Since nitrogen comprises about 78 percent of the atmosphere and is usually the predominant bowel gas, it is assumed that nitrogen gas in the gut is derived from swallowed air. However, nitrogen also may be present as a result of diffusion into the bowel from the blood. Since one cannot differentiate swallowed nitrogen which has diffused into the

gut, it is not possible to speak with certainty as to the origin of this gas in the bowel.

ALTERATION OF DIET AND EFFECT ON GAS PRODUCTION

Research demonstrates that diet can influence the quantity of hydrogen and carbon dioxide produced in the bowel. How can one then manipulate the diet to decrease intestinal gas production? A recent report of a 28-year-old man who had a history of passing excessive flatus may be helpful in understanding how one evaluates and treats flatulence. This individual kept a flatographic diary marking the time of each passage of flatus and eructation as well as all food ingested. He found a daily flatus passage rate of 34 ± 7.3 compared with 13.6 ± 5.6 for age-matched controls. To determine if his gas was due to swallowed air or bacterial production of gases in the colon, rectal gas was analyzed by gas chromatography. The composition of this gas was 38 percent hydrogen, 44 percent carbon dioxide, 17 percent nitrogen, 1.3 percent oxygen and 0.003 percent methane. These results indicate that 82 percent of his rectal gas was hydrogen and carbon dioxide, nonatmospheric gases that could not have been swallowed. To determine what in his diet could be causing the flatulence, the patient began systematically to eliminate foods. He ultimately arrived at a diet which reduced his daily flatus rate to that of control subjects. The patients rated foods as extremely and moderately flatugenic or non-flatugenic. The diet eliminated extremely flatugenic foods such as milk, onions, dried beans, celery, carrots, raisins, bananas, apricots, prune juice, pretzels, bagels, wheat germ, brussels sprouts and moderately flatugenic foods such as pastries, potatoes, eggplant, citrus fruits, apples and bread. Thus, careful dietary evaluation may yield a normal flatugenic diet for individuals producing excessive amounts of gas.

SUMMARY

A rational approach to understanding the role of diet in flatulence requires an analysis of intestinal gas. If the analysis indicates the presence of the atmospheric gases oxygen and nitrogen, swallowed air must be the problem and dietary manipulation would not help. On the other hand, the demonstration of large quantities of hydrogen and carbon dioxide indicates that ingested substrates are reaching the intestinal bacteria and dietary manipulation is in order.

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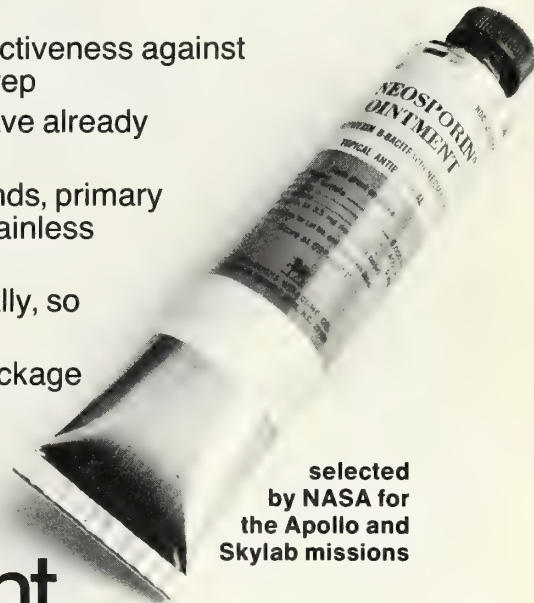
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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THERAPEUTIC DRUG INFORMATION

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Do you have any information on an oral retinoic derivative for the treatment of psoriasis?

The local application of retinoic acid (sold as Aquasol A,[®] Retin-A,[®] and others) generally has been introduced into therapy, although its mechanism of action still remains entirely unknown and irritation limits its clinical efficacy.¹ Systemic administration of retinoids are being investigated for the treatment of various skin disorders. One derivative, RO 10-9359, under investigation by Hoffman-La Roche had been found in animal experiments to be better tolerated and produce a better therapeutic effect than other retinoids.

Frederiksson and Pettersson² conducted a study utilizing RO 10-9359 orally in patients suffering from severe, chronic, generalized psoriasis. The authors found that at 75 to 100 mg daily it proved to be an extremely potent antipsoriatic drug, with more than a 90 percent reduction of psoriatic lesions in 10 out of 20 patients receiving this dose.

Goerz and Orfanos³ conducted a cooperative, multicenter investigation on the activities of oral RO 10-9359 therapy for psoriasis. Data reported on 203 patients indicated the drug to be an effective antipsoriatic agent especially in erythrodermic and pustular types of the disease where it may replace methotrexate.

Schuppli⁴ treated 38 patients suffering from Lichen planus with RO 10-9359. Initial daily doses of 50 to 100 mg were utilized for two to three weeks and then reduced to maintenance dose of 25 mg daily. Good effects were obtained in 31 patients, while no effect was found in three patients. The drug had to be discontinued in the other four patients because of severe side effects. These investigators indicated that RO 10-9359 is a drug of choice in the treatment of the erosive forms of Lichen planus of the oral mucosa.

Side effects reported in various studies included dryness and swelling of lips, mouth and tongue, dermatitis, gastrointestinal disturbances, headache and alopecia.¹⁻⁴ These were reversible after discontinuation of the drug.

In conclusion, the new oral retinoid derivative, RO 10-9359, may be an effective drug for the treatment of psoriasis and Lichen planus. It may offer a viable alternative to the use of cytostatic drugs such as methotrexate. Further studies are required to determine its efficacy and safety.

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2. Do you have any information on a drug to protect against radioactive nuclear fallout?

The recent turn of events, including the proliferation of nuclear power plants and atomic-weapons testing, has focused a concern on the toxic reactions faced by exposed populations in the event of an accident.

The sudden release of radioiodine ¹³¹I represents the most critical acute-term environmental hazard from a nuclear fallout. Inhaled ¹³¹I rapidly accumulates in the body and competes against normal sources of dietary iodine for the thyroid gland, thereby resulting in thyroiditis, hypothyroidism, or thyroid neoplasia with either benign or malignant characteristics.¹

The National Council on Radiation Protection (NCRP), chartered by Congress in 1964, has collected and analyzed recommendations concerning radiation protection. NCRP Report No. 55 discusses the safety and efficacy of thyroid-blocking agents, e.g., perchlorate, propylthiouracil, methimazole (sold as Tapazole[®]), and others and concluded that a saturated solution of potassium iodide (SSKI) is most suitable for minimizing glandular uptake of ¹³¹I.² Greater than 90 percent blocking of radioactive iodine uptake by the thyroid gland can be obtained by the oral administration of 0.13 cc of SSKI immediately before or after initial exposure; 50 percent block is attained if SSKI is given 3 to 4 hours post-exposure.¹ Infants under one year of age are to be given one-half the adult dose of SSKI. Since the half-life of ¹³¹I is approximately eight days, SSKI should be administered daily for up to 10 days under medical supervision.

The Commissioner of the Food and Drug Administration (FDA) recently advised that OTC sales of SSKI may occur if the proper labeling standards with regard to radiation proph-

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; M.K. Fisch, M.S., R.J. Fuentes, R. Ph., P. Sangkachand, M.S.

ylaxis are met. Although a public solicitation for New Drug Applications and availability of labeling requirements was made by the FDA in December 1978, no pharmaceutical firm is currently marketing an OTC SSKI preparation.

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3. Please provide information on amrinone.

The basic treatment of congestive heart failure long has been dependent on use of cardiac glycosides, agents with a narrow therapeutic index. Amrinone is a non-glycoside, non-catechol, positive inotropic agent under investigation by Sterling-Winthrop. It may offer a promising alternative to digitalis. Although its mechanism of action is unclear, it is believed to act directly on myocardial contractile elements in a manner that differs from cardiac glycosides and beta-adrenergic agents.¹

In various experimental models, amrinone reversed all hemodynamic changes associated with acute heart failure.¹⁻³ Dogs with experimentally-induced heart failure received amrinone intravenously and experienced a marked increase in cardiac contractile force and cardiac output with a moderate decrease in diastolic pressure.³ There was no significant change in heart rate, systolic pressure, or the electrocardiogram. The inotropic effect of amrinone increased with increased rate of infusion, and there was a significant decrease of systolic and diastolic blood pressure at higher doses. Oral administration of amrinone in the dog was effective within 30 minutes and lasted for over six hours.

Amrinone was intravenously administered to 20 normal human volunteers for assessment of inotropic potential.⁴ The drug produced a positive inotropic effect with a dose-related

increase in heart rate that never exceeded 100 beats per minute at the highest dosage utilized.

In two preliminary clinical studies, each involving patients with severe congestive heart failure inadequately controlled by maximally tolerated doses of digitalis and diuretics, intravenously administered amrinone stimulated myocardial contractility.^{5,6} Left ventricular function improved in all patients along with improved cardiac output. No subjective or objective clinical manifestations of toxicity were observed with either bolus injection or continuous intravenous infusion. Peripheral vasodilation was reported in some patients which actually may be beneficial in overcoming the vasoconstriction associated with heart failure.

In conclusion, amrinone, a drug that can be given orally as well as intravenously, exerts a positive inotropic activity that is additive to that effect of digitalis. It appears to have a wide therapeutic index. Although short-term efficacy has been demonstrated making it potentially useful in the management of acute heart failure, the long-term efficacy and safety of the drug still must be determined.

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Mammography—A Perspective*

By now it would seem that everything that had to be written about mammography has gone to print. Very rarely has an x-ray examination generated so much interest and controversy.

In the past, until the advent of mammography, very little of significance had been derived from soft tissue radiology. Suddenly a soft tissue x-ray technique was developed by Gershon-Cohen¹ and Egan² which not only promised to identify the presence of a breast lesion, but more importantly to predict with a high degree of accuracy its histology prior to biopsy.

As with all dramatic developments, a tremendous enthusiasm was generated and many radiologists actually subspecialized in this field. We subsequently entered a period of "cooling off," during which we carefully reassessed the patients most suited for mammography.

Most radiologists remain extremely enthusiastic about the technique. We all have encountered many patients in whom a cancer was not palpable, because of its small size or the large size of the breast, and the x-ray clearly demonstrated the cancer.³ We are particularly bewildered by the fact that there is so much resistance on the part of surgeons, internists and gynecologists to what appears to be an excellent examination. This is explained partially by the confusion attending the controversy over mammographic screening of healthy, asymptomatic women.

It is important to bear in mind that psychologically we are not examining a "neutral" part of the body, but one highly charged with sexual connotation. Consider the controversy that would attend screening and diagnostic x-ray evaluation of testicles for testicular carcinoma. One may be sure that many of us would think twice prior to undergoing this kind of examination, no matter what the "experts" had to say.

The statistics suggest that the average American woman faces a seven percent chance of developing breast cancer at some time during her life. The risks range from as low as one in 20 to a high of nearly one in two, depending on genetic and other factors.

Breast malignancy is the leading cancer killer in American women and the leading cause of death in women between the ages of 39 to 44. The statement that every 15 minutes, on the average, three women in this country are diagnosed as having this disease and one woman dies from breast cancer dramatizes the problem.

When breast cancer is detected early, that is, while still confined to the breast without spread to the regional lymph nodes, the ten-year survival rate doubles. Since no dramatic improvement in long-term survival yet has been demonstrated with new surgical, radiotherapeutic and chemotherapeutic techniques, the best chances for survival still lie in

early detection. This places a heavy burden of responsibility on physicians. The dilemma is how to utilize mammography so that we do not unnecessarily irradiate large groups of women, yet we identify those subgroups of women who are most prone to develop cancer and would most benefit from mammography.

What is the price to be paid for the potential saving of lives through mammography? Upton⁴ estimates that one rad increases the natural risk of breast cancer by possibly one percent. Therefore, with the current average doses of mammographic techniques, a woman increases her risk from the natural seven percent chance to 7.07 percent with each mammogram. According to this calculation, approximately 15 mammograms would raise the average woman's risk from seven to eight percent. This does not appear to be a significant risk when compared to the benefits of early detection.

Since the incidence of breast cancer is very low under the age of 35, this is the age usually accepted at which "at risk" patients should undergo mammography. Of the generally accepted risk factors, the first and foremost is age. After the age of 50, women should undergo yearly mammograms because of the dramatic increase in incidence of breast cancer. In my opinion many women of 50 years and over, particularly those with extensive fat replacement in their breasts, need only "one view mammography,"⁵ once a baseline examination of two views has been established. This further reduces the radiation dosage.

The second most important risk factor is a history of previous breast carcinoma. These patients should undergo yearly mammography, regardless of their age.

The gray area of risk factors where physicians differ on the frequency of mammography "relates to *asymptomatic* women under the age of 50 who have a history of chronic cystic mastitis, a family history of breast cancer, early onset of menstruation, no history of pregnancy, first full-term pregnancy at age 30 or older, and high risk mammographic parenchymal patterns."⁶ I would not presume to give a pat answer on this matter, for, if there were one, an article such as this would be unnecessary.

However, women with signs and symptoms relating to the breast should undergo diagnostic mammography. We have seen experienced surgeons who perform biopsies without mammography miss cancers which would have been detected by the mammogram. For every case of this type, that I have experienced, I can only infer how many cases went un-

*The author, Daniel S. Cukier, M.D., is Clinical Assistant Professor of Radiology, New Jersey Medical School, CMDNJ, Newark.

detected until much too late because of failure to obtain a mammogram. Certainly, the economic cost of a mammogram is minimal as compared to the cost of mastectomies and follow-up treatments for metastatic disease. It is therefore important for radiologists to stress the difference between the *diagnostic mammogram* for symptomatic abnormality from *screening mammography* in asymptomatic women. I think it is entirely analogous to obtaining a gastrointestinal series for suspected ulcer disease.

Self-breast examination may alert a woman to abnormal changes in her breasts and encourage her to visit a physician. However, when my clinical colleagues or I palpate an area of "thickening," I personally place limited reliance on our evaluation. Unless an obvious mass is felt, the physician's palpation may be misleading or may yield equivocal information at best. Mammography then is an important complementary procedure to the physical examination since there are more non-palpable carcinomas detectable by mammography than palpable carcinomas that do not show on x-ray. This impression is supported by the 27 Breast Cancer Detection Demonstration Projects⁸ whose statistics revealed that 45 percent of the 1810 cancers discovered were detected by mammography alone, with none of the women having physical findings or complaints.

With present low-dose mammographic techniques^{9,11} and high-filtration xeromammographic techniques¹⁰, central breast tissue doses of 0.05 to 0.5 rads per breast examined easily should be obtainable. The recommended dose of under one rad per breast per examination is entirely feasible. Although lower doses are possible, it is my opinion that these result in a significant degradation of image and that present techniques are entirely satisfactory at acceptable radiation risk levels. Naturally, the value of newer techniques such as ultrasonography of the breast¹² and computer tomography of the breast yet have not been determined.

I firmly believe that we should clearly explain this examination to the public and to our patients to neutralize any misconceptions they may have and to encourage their acceptance of this valuable procedure. Clinicians should aggressively convince their patients of the importance of appropriate use of mammography as a vital individual public health measure.

SUMMARY

Breast cancer, when detected by mammography in the absence of physical findings, has a much higher cure rate.

Women between the ages of 35 and 40 should have one mammogram to be used for future evaluation as necessary. Subsequent examinations depend on risk categories. After age 50, annual mammograms should be performed.

Symptomatic women of any age should undergo diagnostic mammography since self-breast examination and the physician's own subjective impression are of limited diagnostic value. In combination with mammography, cancers will be detected and confirmed which otherwise would be missed, and needless biopsies for benign disease will be reduced.

A more aggressive approach by physicians to convince their patients of the need for diagnostic mammography is recommended. This should be differentiated from the concept of screening of asymptomatic women, in whom evaluation should be made according to individual risk factors.

Daniel S. Cukier, M.D.

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Help for Impaired Physicians

Through its Committee on Impaired Physicians, MSNJ helps doctors who are suffering from alcoholism, other drug addiction, psychiatric disorders, or senility. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early and family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

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Call the Physicians' Confidential Assistance Line (609-896-1884). Only specially trained personnel will answer or return your call.

DOCTORS' NOTEBOOK

Trustees' Minutes October 21, 1979

A regular meeting of the Board of Trustees was held on Sunday, October 21 at the Executive Offices, Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Nominations for AMA Appointments . . .

Agreed that since New Jersey has a candidate for the AMA Board of Trustees (James S. Todd, M.D.), the MSNJ Board should not engage in elective activities other than placing in nomination the following: For the AMA Council on Continuing Physician Education—Arthur Bernstein, M.D.; for the AMA Council on Long Range Planning and Development—William J. D'Elia, M.D.

... Noted that Palma E. Formica, M.D., has been appointed to the AMA Ad Hoc Committee on Women Physicians in Organized Medicine.

AMA Membership . . . Noted that despite efforts of the Ad Hoc Committee on Membership and Dues Collection there had been no substantial increase in AMA membership by New Jersey physicians and urged more effective action.

State Board of Medical Examiners . . . Noted that President Alessi is developing a report on MSNJ's relations with the State Board of Medical Examiners, particularly concerning the use of amphetamines and sympathomimetic amine drugs, to be presented to the House of Delegates at the Special Session on November 18.

... Requested that others involved in this matter be prepared to discuss the matter and uphold the position taken by the Board of Trustees.

Commissioner of Health's Medical Advisory Committee . . . Received a report from President Alessi as a consequence of his attending a meeting of the Health Commissioner's Medical Advisory Committee, (a group involved with the

development of standards for DRGs) which elicited the following:

- Concern that potential conflict might result between the standards established by the Committee and those established by hospitals.
- The need for development of a mechanism to inform and educate physicians on the matter of DRGs.
- The DRG concept is being implemented with 26 hospitals as of January 1, 1980, but the quality screen portion will not be implemented until later. The Commissioner has agreed that any disagreements pertaining to the appropriateness of the quality screens will be assigned to the PSRO for adjudication.
- The New Jersey Hospital Association will convene a committee to evaluate the DRG program. The evaluation will be conducted on an ongoing basis over a period of two and one-half years. Experts from outside the state in the areas of accounting, hospital planning, and others, will be utilized. Purpose of the study is to inform the public, and a final report will be delivered to the public.

... Considered a letter from Percy L. Miller, M.D., who is concerned that the Health Commissioner is aiming for absolute control of medical practice in New Jersey and requested a special meeting of the House of Delegates to consider DRGs. It was deemed that a special meeting was not necessary but that information should be made available to the membership through a special mailing, the *Membership Newsletter*, or an article in *The Journal*, so that when the House meets in May the delegates will be aware of what is taking place with DRGs and be prepared to discuss this item.

Regulations Proposed by the State Board of Medical Examiners . . . Noted the following proposed regulations to be issued by the State Board of Medical Examiners:

a. Release of Patient Records

The State Board of Medical Ex-

aminers is offering a method to preserve physician records when a physician dies or disposes of his/her practice. The regulation provides that:

- Upon termination of a medical practice the individual supervising disposition shall make efforts to notify patients and maintain access to the file for a period of six months.
- Notification must be given in writing to the State Board of Medical Examiners and the professional society (county, regional, or state) where the licensee practiced.
- Notice is to be published once a week for two successive weeks in a newspaper whose circulation encompasses the major geographic area of the licensee's practice.
- Penalty for nonobservance is disciplinary action pursuant to N.J.S.A. 45:1-21.

Note: Rule applies in event of suspension, retirement, death, sale, or insolvency. Disciplinary action can be taken only against licensees.

b. Amphetamines and Sympathomimetic Amines

The State Board proposes to add as an approved indication the "immediate use [of amphetamines] in a hospital for acute conditions such as depression associated with illness—medical or surgical."

Note: Regulation (b) is essentially the same as Resolution #3 from the Burlington County Medical Society, adopted by the 1978 House of Delegates.

Dues' Collection Incentive . . . Noted that an incentive program for transmission of dues by county societies will be announced shortly. A rebate of \$4 per member will be paid for dues transmitted prior to January 1; \$3 per member for dues transmitted prior to February 1; \$2 per member for dues transmitted prior to March 1. It is hoped the program will accelerate dues' collection and serve as a mechanism for determining MSNJ membership in time to permit

accurate apportionment of delegates and in planning the MSNJ budget on a sound financial basis.

1979 Membership Status . . . Noted that as of September 28, 1979 there were 7,733 paid members and 847 dues exempt.

Review of Financial Statements . . . Received the report of the statement of revenue and expenses and the analysis of expenses for three months ended August 31st, and the balance sheet as of the same date, all of which had been reviewed by Mr. Maressa.

MSNJ Student Association . . . Noted that MSNJSA has 294 members (107 new this year), and that a check in the amount of \$1,470 for payment of dues had been delivered to MSNJ.

. . . Authorized allocation of \$2,465 to MSNJSA to balance its 1979-1980 budget.

Conflict-of-Interest Concept . . . Received the following conflict-of-interest statement from the Council on Medical Services to whom Resolution #14 (1979 House of Delegates) had been referred:

The concept of "conflict of interest" has been plaguing thoughtful persons for some time. The Medical Society of New Jersey is no exception, and the Council on Medical Services has been asked to recommend to the Board of Trustees a "position" on this issue.

In the course of daily living all of us "wear several hats"—spouse, parent, taxpayer, citizen, physician, teacher, student, member of a group, religious affiliation, ethnic background, and so on—any of which can influence our bias to a response in a given situation. This can lead to conflicts within the individual, e.g., as a physician I abhor the intrusion of government into "my business" but as a citizen I should applaud the attempts to eliminate fraud and waste of taxpayers' money by physicians. Thus each individual is unique unto himself and no one truly can "represent" somebody else, let alone a group of somebodies.

The practicality of existence, however, mandates that we join together in various endeavors to accomplish an end that is good for the whole as well as the individual. Humans have created "societies" for the very purpose of banding together to present strong influence on other "societies" in the environment.

In a democratic society, persons are

chosen from the group to represent the "majority" of that group and, if the choices are valid, decisions and courses decided upon by the "leadership" should be pleasing and profitable to the whole.

Experience has shown that usually a small minority of the group eventually gravitates to the leadership role and they are then looked upon by others as representatives of the group and therefore asked to fill in with other groups for their input. The same "names" begin to appear on various committees, councils, and boards of related endeavors.

When does the membership on one official body overshadow the responsibility to the original body? For example: can, or should, a physician on the Board of Trustees or the Medical Policy and Fee Committee of Blue Shield remain on the Board of Trustees of MSNJ and be in good faith to both? Can a physician be a member of the board of trustees of a hospital when he is still a member, or an officer of the medical staff? Would it be better to have no doctors on any other "board"; or, as soon as a doctor accepted a position other than fee for service, should it divorce him from any participation in MSNJ deliberations? Obviously these extremes are untenable, but where is the middle ground? Another "out" would be to say some individuals can retain their integrity while representing diverse viewpoints and some cannot, but who is to decide?

We humans tend to reflect our own failing on all other humans and thus the suspicion that "no man can serve two masters" is commonplace and tends not to allow any exceptions. We physicians like to think we have no "master" but as a practical matter, if a major source of income is controlled by another party, it becomes difficult to do it a disservice if one wishes to stay in its favor. Again, from the practical standpoint, this has not proved a major problem since most physicians who have become employees of an organization likely to be in conflict with MSNJ voluntarily have relinquished their positions of authority. And yet they have not relinquished their membership in the Society as indeed they are still members and the House of Delegates has persistently felt that physicians should stay within the organization, no matter where their primary interest lies—teaching, industry, government, or other.

The truly gray area is that of voluntary (no major source of income) participation in a capacity which may pit physician against physician. We physicians

have faced this issue many times and indeed are one of the few groups who have developed methods of self-appraisal and discipline through peer review, therapeutic committees, tissue committees, privilege delineation and so on. Who else but another physician can best judge or appreciate the realities of the science and the art?

Physicians of integrity will voluntarily disqualify themselves from participation and/or voting when they feel their bias is a factor in the issue.

. . . Adopted Part 1 of the following proposed policy statement concerning conflict of interest:

1. In cases where a majority of the Board of Trustees of MSNJ or the House of Delegates feels there is a disabling conflict of interest in a physician's status, he/she:

- a. Should be asked to resign voluntarily from one or the other.
- b. Failing to do so voluntarily, he/she should be removed from a position of authority in MSNJ.
- c. **This shall not pertain to the House of Delegates, but is applicable to officers, members of the Board, and chairmen of major councils and committees.**

. . . Tabled Part 2 of the policy statement until the November 11 meeting of the Board, pending clarification of the meaning of the words "prejudice" and "conflict" and rewording by Mr. Maressa.

Annual Meeting . . .

1. Dates and Location . . . Approved a recommendation from the Committee on Annual Meeting that the 214th Annual Meeting of the Medical Society of New Jersey be held at the Meadowlands-Hilton Hotel in Secaucus May 9-13, 1980.

2. Reference Committee meetings . . . Defeated a recommendation that reference committee meetings in 1980 be scheduled two weeks prior to the annual meeting to consider the bulk of the reports and resolutions and again during the annual meeting to consider emergency material.

Note: In view of the change in date and location of the annual meeting, the Board was not in favor of compounding scheduling problems for delegates and the county societies this year. It was the consensus that the recommendation be

proposed at another time.

3. Annual Prayer Breakfast . . . Approved a recommendation to eliminate the Annual Prayer Breakfast.

Committee on Negotiations . . . Adopted the recommendations of the Committee on Negotiations that the following policy guidelines (with editorial changes), which are in accord with the recommendations of the Council on Medical Services, adopted by the Board at its August 8, 1979 meeting, be approved:

1. Definition of "Negotiations"

For Society purposes, "negotiations" is defined as a formal meeting between specifically appointed Society officials and the official representatives of government, labor, an association, an industry, company or an organized group of individuals, the purpose of the meeting being to seek to resolve favorably a matter of significant importance to the Society.

Determination of whether the matter is of "significant importance" and subject to formal negotiations shall be made by the House of Delegates, the Board of Trustees, or the Executive Committee.

Specifically excluded from the definition of "negotiations" are all legislative matters, for which the Council on Legislation has authority to determine interim policy and to seek the best solutions.

2. Areas of Negotiation

It is expected that most negotiation efforts will occur in the areas of governmental regulatory programs and socioeconomics. Examples are proposed or operational governmental programs which interfere in the physician/patient relationship, burden physicians through increased regulatory procedures, limit physician activity, expand the inappropriate activity of nonprofessionals, or penalize physicians collectively through the imposition of unfair reimbursement programs. In the area of socioeconomics, these same examples would apply to the policies and programs of insurance companies and plan administrators.

The need for formal negotiations also may occur in the relationships which physicians have with hospitals and extended care facilities.

Negotiation efforts also may be needed in the areas of medical education, public relations, and with health professions such as pharmacists, nurses, and others.

3. Source of Board of Trustees Authority to Conduct Negotiations

The Board of Trustees shall be responsible for the Society's overall negotiations program, providing for the selection, training, and direction of negotiators, and, when necessary, providing emergency policy guidance required by the negotiators.

4. Principles to Guide Negotiators

a. No individual Society member, Society component, group of members, staff, or legal counsel shall initiate any formal negotiation effort on behalf of the Society without the prior approval of the House of Delegates or the Board of Trustees. In the event that the need for action precludes presentation of the issue to the House of Delegates or the Board of Trustees, approval to negotiate may be granted by the Executive Committee (whose members are the President, President-Elect, First Vice-President, Second Vice-President, Immediate Past President, and Chairman of the Board of Trustees). Actions of the Executive Committee to grant authority shall be reported immediately to the full Board of Trustees for approval. Actions of the Board of Trustees shall be reported to the House of Delegates at each regular session. Any subsequent disapproval by the Board of Trustees or House of Delegates shall suspend that negotiation effort.

b. The formal negotiation program shall not include activities to assist an individual Society member to resolve a dispute with a third party. Individual members will continue to be served in this regard by councils, committees, and staff of the Society. However, when it is apparent that a number of Society members are, or may be, experiencing the same difficulty with a third party, then this dispute may be subject to formal negotiations.

c. Negotiators shall be guided by a set of specific principles developed for the issue being negotiated. These principles shall define:

- (1) The Society's policy on the issue.
 - (2) The specific points to be negotiated.
 - (3) The desired results.
 - (4) The limits beyond which negotiations may not extend.
 - (5) Reporting procedures to be followed subsequent to each negotiation effort.
- These principles will be developed prior to any negotiation effort by the House of Delegates, the Board of Trustees, or the Executive Committee.

d. Guided by these principles, nego-

tiators shall have the authority to commit the Society to a certain course of action.

5. Role of the President

The President shall oversee all negotiations efforts. He shall:

a. Receive all negotiation requests offered by boards, councils, committees, members, staff, or legal counsel.

b. Determine whether existent Society policy supports or precludes the proposed negotiation effort. In the absence of needed Society policy, the President shall secure policy determination from the House of Delegates, Board of Trustees, or Executive Committee, whichever is indicated.

c. Request the approval of the House of Delegates, Board of Trustees, or Executive Committee to proceed with negotiations.

d. Appoint the negotiators (subject to the procedures outlined in 6 below).

e. Secure from a policy body the necessary specific principles needed to guide the negotiators.

f. Arrange the negotiations meeting.

g. Receive reports and report progress to the appropriate Society policy group.

6. Qualifications and Appointment of Negotiators

a. Negotiators shall be selected on the basis of: (1) their knowledge of the field or of the specific issue to be negotiated; (2) their ability to negotiate as evidenced by their formal training in negotiations and/or their proven leadership in Society affairs. Executive staff and legal counsel may be selected for appointment.

The expertise of the Society's allied medical organizations may be utilized through the appointment of qualified, individual members of those organizations.

b. The President may appoint all negotiators.

(1) In the selection process, he shall consult with the President-Elect and any other Society official considered knowledgeable in the specific negotiations area.

(2) An initial pool of negotiators shall be appointed and trained. This first group of negotiators shall be composed primarily of individuals with expertise in the socioeconomic area. These appointments shall be approved by the Board of Trustees.

(3) As negotiable issues are identified, the President shall appoint teams of negotiators selected from the pool and

the negotiators shall be approved by the parties represented.

(4) Subsequently, if negotiators are needed for areas or issues not covered by the expertise of the pool, the President shall make the necessary new appointments, and notify the Board of Trustees at the earliest opportunity.

c. Appointments shall be at the discretion of the President.

7. Reports of Findings, Agreements, or Recommendations

Negotiators shall have the responsibility to report their findings, agreements, or recommendations to the Board of Trustees for approval. The Board of Trustees, which has the authority to make interim policy decisions, shall then report these activities to the House of Delegates for ratification.

8. Training of Negotiators

To assure the highest possible level of competence of Society negotiators, those appointed will be required to take formal training. The primary training program will be that conducted by the American Medical Association.

9. Reimbursement of Negotiators

When assigned to negotiate a specific issue, negotiators may be reimbursed.

Audit Committee . . . Accepted the financial statements of the external auditors, Ernst & Whinney, and agreed to continue employing that firm as the Society's external auditors.

Ad Hoc Committee on Drug and Alcohol Abuse . . . Adopted the following recommendation from the Ad Hoc Committee on Drug and Alcohol Abuse and referred it to the Academy of Medicine for possible implementation and input from the Department of Health, the office of the Attorney General, the State Board of Medical Examiners, and the Committee on Impaired Physicians.

That MSNJ endorse a specific education program for all physicians to address their role in the significant problem of drug and alcohol abuse.

Committee on Long Range Planning and Development . . .

1. Voting Privileges for MSNJSA members . . . Took the following actions on recommendations from the Committee on Long Range Planning and Development:

a. That MSNJ Bylaws be amended to authorize members of MSNJSA to serve as voting delegates at sessions of the House of Delegates.

. . . Approved and referred to the Committee on Revision of Constitution and Bylaws.

b. That at the outset representation be at least one voting delegate from each of the three medical schools (New Jersey Medical School, Rutgers Medical School, and the New Jersey School of Osteopathic Medicine).

. . . Approved and offered in an advisory capacity to the Committee on Revision of Constitution and Bylaws.

c. That in the future, representation be based on one delegate for every 100 members or major fraction thereof.

. . . Referred without comment to the Committee on Revision of Constitution and Bylaws.

d. That student delegates be elected to annual terms.

Approved.

Note: The issue of slotted representation for medical students on the Board was considered. It was the consensus that this would be impractical without using such representation for other segments within the Society—specialty societies, component societies. The item was postponed indefinitely.

2. Composition of the House of Delegates . . .

a. Speciality Societies . . . Approved the following recommendation amended by the Board:

That in order to accomplish representation of specialty societies in the House of Delegates, each specialty organization designate a delegate from one of the component societies who is a member of the particular specialty group to represent that group's views in the House; the specialty society shall be designated in some visible manner on the badge of the delegate so named.

b. Size of the House of Delegates . . . Requested that the Executive Director supply the Committee on Long Range Planning and Development with current membership figures along with possible formulas for reducing the number of delegates allotted to each county.

3. State Board of Medical Examiners . . . Accepted the suggestion that MSNJ's relationship with the State Board of Medical Examiners be continued along the lines agreed upon at the August 8, 1979 meeting of the Board of Trustees, which were:

a. Assign the President-Elect as its official liaison to the State Board.

b. Continue the policy of assigning a rotating trustee to attend monthly meetings of the State Board.

c. Request the Executive Director to designate a staff member to attend the monthly meetings of the Board of Medical Examiners. Subsequently, Mr. Maressa assigned this responsibility to Martin E. Johnson, Director of Public Affairs and Medical Education.

Principles of Medical Ethics . . . Agreed to include the reports of the AMA Ad Hoc Committee on Principles of Medical Ethics as an informational item with the materials being supplied to the House of Delegates for the special session on November 18. Final action on these documents will be taken at the annual meeting in May 1980.

Op-Ed, Pro-Con Editorials . . . Suggested in response to *The Journal* Editor's request for help in providing the names of potential authors for pro and con editorials on current state and local political issues that the AMA Office of Professional Relations be asked for assistance.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Your Foundation wishes all MSNJ members and their families the very best for the Holidays and the New Year. We close out the seventies and stand on the threshold of the eighties. The next decade starts with a presidential election year. Most candidates will be promising all kinds of benefits to be gained from his favorite "health care" proposal. The promises expand, but the regulations usually tend to constrict what will be available. If the remaining obstacles are removed, New Jersey's rate-setting system is to get under way next month. The first group of hospitals will begin using the DRG system. The medical staffs of those hospitals will be exposed to new ways of documenting in-patient care. Their experience should be of great interest to the rest of us. The emphasis will be on cost-effectiveness and efficiency. These are worthwhile goals, provided that quality assurance by professional peer review is maintained.

Special Committee on Long Range Planning and Development

The copy of the 1979 annual report of the Special Committee on Long Range Planning and Development submitted to *The Journal* for publication in the *Transactions* issue did not contain the last two paragraphs of the report. The complete report is here presented:

During the past year we considered whether or not specialty societies should be given representation in the Medical Society of New Jersey's House of Delegates.

Obviously, this is an issue which can and will become emotionally charged. It is our belief that such representation should be extended to all specialty societies in New Jersey which are affiliated with national specialty societies recognized by the AMA. The Board of Trustees has referred our report to the Committee on Constitution and Bylaws for report to the House of Delegates at a session subsequent to the 1979 Annual Meeting.

Our Statement of Goals as approved by the Board of Trustees is as follows:

STATEMENT OF GOALS

The Committee believes that if the Society is to be effective in a long-range planning and development effort it must, of necessity, look toward the goals it has set, i.e., a viable, effective association to advance the interests of the practitioners of medicine through scientific, educational, socio-economic, and legislative programs; evaluate the barriers and the means to achieving the desired goals; and implement the mechanisms to carry through to completion.

In order to reach an awareness that problems do indeed exist, and as a method of starting to deal with these problems, the Committee on Long Range Planning and Development recommends that at the Annual Meeting of the Medical Society of New Jersey the chairmen of the reference committees be charged with making a list of problems that become evident during their meetings; and that such lists be presented to the President and to the Board of Trustees for referral to the Committee on Long Range Planning and Development and other appropriate committees for study and recommendation during the next year. The Committee will, of course, continue to study and explore areas as it deems advisable.

The Committee on Long Range Planning and Development concurs with the charges as developed by the Council on Long Range Planning and Development of the AMA which state:

"The functions of the Council on Long Range Planning and Development are:

"To study and make recommendations concerning the long-range objectives of the Association.

"To study and make recommendations concerning the projected resources, programs and organizational structure by which the Association attempts to reach its long-range objectives in the above.

"To serve as a focal point for the planning activities of the Association and to stimulate and evaluate planning activities throughout the organization.

"To study, or cause to be studied, the future environment in which medicine and the Association must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision-making centers throughout the Association, and submit reports to the House of Delegates at appropriate times."

The Society cannot continue to be simply traditional or historical in its reaction to pressing problems. We need to develop a logical and consistent position on many current issues which include ancillary personnel, relationships with those with limited licenses, conflict of interest, and fee restraints. The environment in which medicine and the Society must function demands decisive attitudes and actions in reasonable harmony with the community and the nation.

These basic issues must be resolved. We trust that the board is prepared to make indicated changes in strategy, policy and operational format.

NOTICE

**The Academy of Medicine
of New Jersey announces
the removal of its office to:**

**Two Princess Road
Lawrenceville, NJ 08648**

**Telephone:
(609) 896-1717**

CMDNJ Notes*

**Stanley S. Bergen, Jr., M.D.
President**

COLLEGE HOSPITAL ACCREDITED

Following close on the heels of the full accreditation awarded CMDNJ this summer by the Middle States Association of Colleges and Schools, CMDNJ's newest unit, College Hospital, in Newark, has been awarded full two-year accreditation by the Joint Commission on Accreditation of Hospitals (JCAH).

JCAH is the national agency which sets standards for institutions' medical care, surveys hospitals which request it, and accords them a degree of accreditation when merited. The agency is composed of four distinguished health care and professional organizations—the American College of Physicians, American Hospital Association, the American College of Surgeons and the American Medical Association.

We at CMDNJ take particular pride in this acknowledgement bestowed by JCAH because it came only a little over a half-year after College Hospital opened last January to replace Martland Medical Center as the primary teaching hospital of the CMDNJ-New Jersey Medical School and as a major health care provider to the people of Newark and referral center for New Jerseyans.

Leading to the accreditation, a panel of health care professionals, including doctors, nurses and administrators, visited College Hospital last spring for an onsite inspection of the physical plant and a review of services in patient care, administration, and support areas. The JCAH Board of Commissioners then reviewed the panel's findings to render its decision.

The 560-bed, \$76-million College Hospital is located on the 46-acre Newark campus. The nine-level structure, with three patient-care wings and a range of specialty clinics and outpatient services, represents the completion of a \$200-million construction project on the campus.

PSYCHIATRIC UNIT

Service improvements continue at College Hospital. A 38-bed acute psychiatric in-patient unit soon will be created on the hospital's "G" Level, following approval of the plan by the Statewide Health Coordinating Council (SHCC). A major advantage of installing the unit in College Hospital is that it

will result in a considerable saving of state funds, while at the same time, provide a well-designed therapeutic area to permit the most progressive approach to treatment of acute psychiatric patients. The approximate cost of renovating the "G" Wing of College Hospital is \$344,000, while the estimated cost of putting the unit above the mental health center (an earlier plan) is more than \$2.3 million.

In addition, the "G" Level renovation will save operating expense and the shorter completion time will cut considerably into the current expense of maintaining the Martland psychiatric unit in a building that is otherwise empty.

AMBULANCE SERVICE FOR NEWARK

In another development connected with College Hospital, the direction and management of ambulance services for the City of Newark have been assumed by CMDNJ, under an agreement signed by both City and State officials. The five-year contract which went into effect November 1 calls for the State and the City to share the cost of the service. Under its terms, CMDNJ ultimately will provide Newark with a total of eight ambulances, with five in active service on each of three work shifts, around the clock.

The special arrangement with the City of Newark is based on agreements made by the State of New Jersey in 1968. When the State acquired Martland Hospital from Newark as a facility for CMDNJ, the College was committed to maintain certain health services which were based at the City facility. This included the emergency transportation system at the level then being provided by the City of Newark.

The agreement calls for the City to pay the State \$450,000 on January 1, 1980, to supplement the \$730,000 budgeted by the College for ambulance service and emergency communications, in fiscal year 1979-80. The City's payment partly reflects remuneration for services which have been supplied by the College since July 1. The City also will reimburse the State for half the costs of the new ambulances the following January.

In subsequent years of the contract, which expires June 30, 1984, the State will continue to supply a base of \$738,000 as adjusted for salary increases and inflation; and any increase above that level which is needed to supply the service will be shared equally by the City and State.

Fellowship in Medical Journalism

The 1980-1981 American Medical Association **Dr. Morris Fishbein Fellowship in Medical Journalism** will be held from Sept. 2, 1980 through June 30, 1981.

PROGRAM

This ten-month program will integrate the interests of the person to whom the fellowship is awarded with the various publishing activities of the American Medical Association. The range of training activity will include assigned periods during which the participant will serve as a special staff member of such publications as *JAMA* and *AM News*. The fellowship winner will participate in all duties performed by the senior staff such as assessment of manuscripts for publication, library research for articles, copy editing and correspondence. Some writing and interviewing may be assigned. However, the program is not restricted to writing and editing. Training segments devoted to production, art preparation and handling, purchase of printing, advertising marketing and sales, and circulation fulfillment will be offered.

ELIGIBILITY

Applicants should be completing their final year of medical school, internship or residency not later than July 1, 1980, or be presently practicing medicine, and must have expressed an interest in journalism by having been editor or staff member of a university publication, worked part or full time for, or published in, a scientific journal or newspaper. Willingness to participate as a full-time, temporary employee is essential to the success of the fellowship program both for the participant and the AMA.

APPLICATION

Application forms are available from the AMA, 535 North Dearborn Street, Chicago, Illinois 60610, and the completed form, signed and dated, must be received by January 11, 1980. The applicant chosen will be notified by February 15, 1980.

FINANCES

The participant is responsible for travel expenses between his place of residence and Chicago and for his housing and meals while in attendance. A monthly stipend, first issued on September 26, 1980, of not less than \$1960 will be offered; the participant will be an employee of the AMA with applicable benefits.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Stanley Goldstein, M.D., 1525 Millerspost Highway, Williamsville, NY 14221. New York Medical 1975. Sub-specialty, pediatrics. Board eligible (pediatrics) Solo, partnership, research. Available July 1980.

Prasad Srinivasan, M.D., 2951 S. King Drive, Apt. 1808, Chicago, IL 60616. Baroda (India) 1972. Special interests, immunology, pediatrics. Board certified (pediatrics). Partnership, single or multi-specialty group. Available July 1980.

Dfraim Lavi, M.D., 8320 SW 65th Avenue, Apt. 12, Miami, FL 33143. Sackler (Israel) 1975. Partnership, single or multi-specialty group. Available July 1980.

ANESTHESIOLOGY—Subhash Chander, M.D., 264-16 74th Avenue, Glen Oaks, New York 11004. Government College, Punjab (India) 1972. Solo, single-specialty group, institutional. Available July 1980.

Chung B. Park, M.D., 1925 Eastchester Road, Apt. 22-C, Bronx, NY 10461. Kyungpook (Korea) 1971. Board eligible. Partnership, single or multi-specialty group. Available July 1980.

Abhijit Desai, M.D., 435 E. 70th Street, Apt. 21-C, New York, NY 10021. Seth G.S. Medical (India) 1973. Board eligible. Partnership, single-specialty group, institutional. Available July 1980.

Dhan Raj, M.D., 308 North Hite, Apt. 10, Louisville, KY 40206. Osmania (India) 1973. Solo, partnership, multi-specialty group. Available July 1980.

CARDIOLOGY—Joseph Chathampadathil, M.D., 3910 Powelton Avenue, Apt. 505, Philadelphia, PA 19104. Trivandrum (India) 1968. Also general internal medicine. Board certified (IM). Institutional, solo, or group. Available July 1980.

Barton E. Cohen, M.D., 166 East 34th Street, Apt. 10-G, New York, NY 10016. NYU 1975. Subspecialty, cardiology, Board certified. Group, partnership. Available July 1980.

George Demidowich, M.D., 501 Stuyvesant Avenue, Irvington 07111. New York Medical College 1975. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1980.

Sudhir Amaram, M.D., 1310 Pennsylvania Avenue, Apt. 12-E, Brooklyn, NY 11239. Osmania (India) 1973. Also general internal medicine. Board certified (IM). Partnership, group, solo. Available July 1980.

Roger N. Zitrin, M.D., 8 Micieli Place, Brooklyn, NY 11218. Rutgers 1974. Group, partnership, solo. Available January 1980.

Stephen K. Kwan, M.D., Deborah Heart

and Lung Center, Browns Mills, NJ 08015. Natl. Defense Med. Center (Taiwan) 1972. Solo, group, hospital-based. Available July 1980.

M. Tejura, M.D., 3401 Gibraltar Heights, Apt. J-5, Toledo, OH 43609. Topiwalla (India) 1974. Solo, partnership. Available July 1980.

CARDIOVASCULAR DISEASES—Alan Feit, M.D., 88 Howard Park Drive, Tenaflly 07670. Columbia 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, institutional. Available July 1980.

Joel A. Roffman, M.D., 282 Washington Street, Apt. B-2, Hartford, CT 06106. Boston 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

Kandathil M. Mathew, M.D., 22 Woodland Park, Hartford, CT 06105. Kasturba (India) 1969. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership, solo. Available July 1980.

Sudhir Amaram, M.D., 1310 Pennsylvania Ave., Apt. 12-E, Brooklyn, NY 11239. Osmania (India) 1973. Also, general internal medicine. Board certified (IM). Any type practice. Available July 1980.

James A. Quinn, M.D., 3 Washington Square, Euclid, OH 44143. Columbia 1974. Also, general internal medicine. Board eligible (IM). Single-specialty group, partnership, institutional. Available July 1980.

George Demidowich, M.D., 501 Stuyvesant Avenue, Irvington 07111. New York Medical 1975. Also, general internal medicine. Board certified (IM). Single-specialty group, partnership, solo. Available July 1980.

Arnold J. Greenspon, M.D., 922-C Chatham Lane, Columbus, OH 43221. University of Pennsylvania 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, institutional. Available July 1980.

Stanley M. Lewis, M.D., 14 Third Avenue, Branford, CT 06405. Albany 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, institutional. Available July 1980.

Vidyadhar R. Gandra, M.D., 1350 W. Bethune Avenue, Apt. 907, Detroit, MI 48202. Gandhi (India) 1972. Also, general internal medicine. Board certified (IM). Partnership, single-specialty group, solo. Available August 1980.

James D. Lynch, M.D., 3732 Lowell Road, Cleveland Heights, OH 44121. Hahnemann 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

Jay I. Lipoff, M.D., 3188 Skinner Mill Road, Apt. 9-G, Augusta, GA 30909. NYU 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

DERMATOLOGY—David L. Cohen, M.D., 3228 Johnson Avenue, Riverdale, NY 10463. Mount Sinai 1976. Partnership, solo, multi-specialty group. Available July 1980.

ENDOCRINOLOGY—Howard M. Lando, M.D., 8105 Kane Court, Alexandria, VA 22308. Medical College of Virginia 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership, research. Available July 1980.

Jack Cukierman, M.D., 215 Stearns Hill Road, Waltham, MA 02154. SUNY-Buffalo 1975. Also, general internal medicine, with special interest in diabetes. Board eligible (IM). Single or multi-specialty group, partnership. Available July 1980.

FAMILY PRACTICE—Frazil Kideys, M.D., 17 Agate Street, East Brunswick 08816. Istanbul 1953. Board eligible. Partnership or solo. Available.

Eric N. Kruger, M.D., Hunter Hills, G-4, Flemington 08822. Jefferson. Group, partnership, solo. Available July 1980.

James M. Lynch, Jr., M.D., 1623 Parkcrest Circle, Apt. 300, Reston, VA 22090. Guadalajara 1976. Single or multi-specialty group, partnership. Available July 1980.

Mark S. Weitman, M.D., 5615 Phillips Avenue, Apt. 3, Pittsburgh, PA 15217. SUNY-Buffalo 1977. Institutional, partnership, single-specialty group. Available July 1980.

GASTROENTEROLOGY—Norman Zitomer, M.D., 1113 Rodman Street, Philadelphia, PA 19147. SUNY-Downstate 1975. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1980.

Iftikhar A. Malik, M.D., 175 Willoughby Street, Apt. 5-F, Brooklyn, NY 11201. King Edward (Pakistan) 1973. Also, general internal medicine. Board eligible (IM). Solo, partnership, institutional. Available July 1980.

Ira E. Mayer, M.D., 3193-D Buford Highway, NE, Atlanta, GA 30329. New York Medical 1975. Also, general internal medicine. Board certified (IM). Research, single or multi-specialty group. Available July 1980.

John J. Sheehan, Jr., M.D., 589 Country Club Lane, Nashville, TN 37205. Pennsylvania State 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

Prafulla K. Kirtane, M.D., 73-05 150th Street, Apt. 3-A, Flushing, NY 11367. Baroda (India) 1973. Also, general internal medicine. Board certified (IM). Solo, multi-specialty group, partnership. Available July 1980.

Allan M. Effron, M.D., P.O. Box 593, Woodcliff Lake 07675. Guadalajara 1974. Single or multi-specialty group, partnership. Available July 1980.

David L. Gottesman, M.D., 13357 Cedar Road, Cleveland Heights, OH 44118. NYU 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, solo. Available July 1980.

Indira R. Kalram, M.D., 34 Gardner Street, Apt. 43, Boston, MA 02134. Andhra (India) 1973. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

George M. Cibik, M.D., 2991 School House Lane P14W, Philadelphia, PA

19144. Albany 1975. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

GENERAL PRACTICE—Thomas W. Lister, M.D., Route 3, Box 417 CD, Cameron, TX 76520. University of Texas 1968. Group, partnership, industrial, student health. Available.

Carlos A. Viola, M.D., 115 Oakglen #207, Port Lavaca, TX 77979. Buenos Aires 1950. Special interest, general surgery. Multi-specialty group, institutional, solo. Available January, 1980.

INTERNAL MEDICINE—Bennett H. Bruckner, M.D., 192 Garth Road, Apt. 6-M, Scarsdale, New York 10583. Emory 1973. Board eligible. Group, partnership, solo. Available.

Jan Stanley Glowacki, M.D., 29 Maple Avenue, Fair Haven 07701. Jefferson 1977. Board eligible. Solo, partnership, group. Available July 1980.

Miguel A. Maseda, M.D., 106 Fifth Avenue, Bradley Beach 07720. Madrid 1977. Board eligible. Solo, group, partnership. Available July 1980.

Iradj Shairm, M.D., 89 Central Avenue, Morrisville, PA 19067. Iran 1970. Board certified. Partnership, group. Available.

Richard J. Fastiggi, M.D., 14 W. Cold Spring Lane, Apt. 302, Baltimore, MD 21210. CMDNJ 1977. Board eligible. Emergency room. Available July 1980.

Patricia Costanzo, M.D., 12 Tory Court, Colts Neck 07722. CMDNJ 1974. Subspecialty, pulmonary medicine. Board certified. Any type practice. Available July 1980.

Thomas Pitoscia, M.D., 19 Upper Overlook Road, Summit 07901. Rush 1977. Multi-specialty group, partnership, industrial, academic. Available July 1980.

Mohammad A. Chaudhry, M.D., 16 Farmhouse Road, Mountain Top, PA 18707. King Edward (Pakistan) 1963. Board certified. Partnership, single or multi-specialty group. Available July 1980.

Yallappa Nadiminti, M.D., 605 Louisiana Avenue, Apt. 168, Brooklyn, NY 11239. Government Medical College (India) 1973. Subspecialty, neoplastic diseases. Board certified. Solo, institutional, partnership, single or multi-specialty group. Available July 1980.

Douglas R. Shumaker, M.D., 7861 Jefferson Street, Hummelstown, PA 17036. George Washington University 1977. Partnership, single or multi-specialty group, solo, emergency room. Available July 1980.

Joel M. Cohen, M.D., 1131 University Boulevard West, Apt. 1404, Silver Spring, MD 20902. SUNY-Downstate 1975. Subspecialty, cardiovascular diseases. Board certified. Single or multi-specialty group, partnership. Available July 1980.

Sybil Kramer, M.D., 68 Winchester Street, Brookline, MA 02146. SUNY-Downstate 1975. Subspecialty, endocrinology. Board certified. Single or multi-specialty group, partnership. Available July 1980.

Mark L. Friedman, M.D., 2901 S. King, Apt. 1003, Chicago, IL 60616. University of Chicago 1977. Subspecialty, emergency medicine. Single or multi-specialty group, partnership. Available July 1980.

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Robert H. Gordon, M.D., 5500 Wissahickon Ave., Apt. 405-C, Philadelphia, PA 19144. Jefferson 1975. Subspecialty, rheumatology. Board certified. Any type practice. Available July 1980.

Lawrence P. Saladino, M.D., 3428-B Alpine Court, Lexington, KY 40502. Georgetown 1975. Subspecialty, emergency medicine. Institutional, multi-specialty group, emergency room. Available July 1980.

Laurence J. Clark, M.D., 5038 Cliffhaven Drive, Annandale, VA 22003. Georgetown 1975. Subspecialty, emergency medicine. Partnership, solo, emergency room. Available July 1980.

Devi P. Misra, M.D., 7K University Terrace, Columbia, MO 65201. SCB Medical College (India) 1967. Subspecialty, pulmonary medicine. Board certified. Solo, institutional, group. Available July 1980.

Jon Allen Kotler, M.D., c/o Dept. of Medicine, 1356 Lusitana Street, Honolulu, HI 96813. Emory 1976. Subspecialty, emergency medicine. Board eligible. Single or multi-specialty group, partnership. Available January 1980.

Howard L. Kramer, M.D., 4 Longfellow Place, Apt. 803, Boston, MA 02114. Florida 1975. Board certified. Single or multi-specialty group, partnership. Available February 1980.

Mirza M. Ashraf, M.D., West St. Road, Carthage, NY 13619. King Edward (Pakistan) 1967. Subspecialty, cardiovascular diseases. Solo, single-specialty group, institutional. Available January 1980.

Mohamed M. Haq, M.D., 10555 Fondren, Apt. 422, Houston, TX 77096. Osmania (India) 1973. Subspecialty, neoplastic diseases. Board certified. Single or multi-specialty group, research. Available July 1980.

Jay Kaplan, M.D., 140 Kane Street, Apt. D-2, West Hartford, CT 06119. Bologna (Italy) 1977. Partnership, single or multi-specialty group. Available July 1980.

NEOPLASTIC DISEASES—Arlene A. Forastiere, M.D., 10 Waterside Plaza, Apt. 3-J, New York, NY 10010. New York Medical 1975. Subspecialty, hematology. Board certified (IM). Single-specialty group, institutional, research. Available July 1980.

NEPHROLOGY—Dinesh Shukla, M.D., 514 E. 88th Street, Apt. 2-B, New York, NY 10028. Maulana Azad (India) 1973. Subspecialty, general practice. Partnership, single or multi-specialty group. Available July 1980.

Alan S. Terlinsky, M.D., 1938 McFalls Street, McLean, VA 22101. Georgetown 1975. Also, general internal medicine. Board certified (IM). Partnership, solo, single-specialty group. Available June 1980.

Joon Koo Yeo, M.D., 5460 Bahama Terrace, Apt. 9, Cincinnati, OH 45223. Seoul (Korea) 1970. Also, general internal medicine. Board certified (IM). Partnership, single or multi-specialty group. Available July 1980.

NEUROLOGY—Eugene C. Madonia, M.D., 11105 Troy Road, Rockville, MD 20852. Georgetown 1976. Single or multi-specialty group, partnership. Available July 1980.

Richard B. Brooks, M.D., 1 David Lane, Yonkers, NY 10701. SUNY-Upstate 1976. Board eligible. Partnership, single or multi-specialty group. Available July 1980.

Chitpadi R. Dandillaya, M.D., 16 Harper Terrace, Cedar Grove 07009. Osmania (India) 1962. Also, general internal medicine. Board eligible. Multi-specialty group, partnership, solo. Available July 1980.

Palanivel G. Moorthy, M.D., Aring Neurology Center, Pavilion B, Buc Medical Center, Cincinnati, OH 45267. Kilpauk (India) 1968. Board eligible. Solo, partnership, multi-specialty group. Available July 1980.

Seung K. Rho, M.D., 1700 Seaspray Court, Apt. 1233, Houston, TX 77008. Seoul (Korea) 1970. Subspecialty, psychiatry. Board eligible. Solo, group or research. Available January 1980.

OBSTETRICS/GYNECOLOGY—Theodore Kohn, M.D., 6441 N. Francisco Avenue, Chicago, IL 60645. Mexico 1962. Board eligible. Solo, partnership, group. Available.

Kahlid Parwez, M.D., 420 Stockholm Street, Apt. C-9, Brooklyn, New York 11237. Nishtar (Pakistan) 1971. Board eligible. Group, partnership, association. Available July 1980.

Robert A. Stern, M.D., 7 Balint Drive, Apt. 128, Yonkers, NY 10710. New York Medical College 1976. Board eligible. Group. Available July 1980.

Sung Ho Lee, M.D., 400 Elruth Court, Apt. 141, Girard, OH 44420. Seoul (Korea). Solo, group, or associate. Available July 1980.

Robert J. Lipari, M.D., Jewish Hospital and Medical Center, 555 Prospect Place, Brooklyn, New York. Bologna (Italy) 1975. Board eligible. Group or partnership—flexible. Available July 1980.

Woo-Gill Jeong, M.D., 203 Churchill Hubbard Road, #4, Youngstown, OH 44505. Chonnam (Korea). Board eligible. Group or partnership. Available July 1980.

Dhanalakshmi Venkataraman, M.D., Kensington Arms, Apt. 22-B, Hightstown 08520. Jabalpur (India) 1969. Board eligible. Partnership, hospital-based, group, solo. Available June 1980.

Balu G. Kamalapurker, M.D., 150 55th Street, Brooklyn, NY 11220. Karnatak (India) 1974. Board eligible. Single or multi-specialty group, partnership. Available July 1980.

Shawky N.F. Habashy, M.D., 1408 South Country Club, Carlsbad, NM 88220. Ain Shams University (Egypt) 1965. Board certified. Single or multi-specialty group, partnership. Available March 1980.

Michael T. Kicenuik, M.D., 49 Crescent Road, Livingston 07039. CMDNJ 1972. Board eligible. Any type practice. Available July 1980.

W.L. Schneiderman, M.D., 287 Belblossom Way, Los Gatos, CA 95030. New York Medical 1974. Board eligible. Group or partnership. Available March 1980.

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Jyotsna S. Mehta, M.D., 729 Village Drive, Edison 08817. Seth (India) 1973. Single or multi-specialty group, partnership. Available July 1980.

Jose Cohen, M.D., 2627 Maxwell Street, Philadelphia, PA 19152. Cordoba (Argentina) 1974. Solo, partnership, single-specialty group. Available July 1980.

Inchul Park, M.D., 736 Carter Street, Apt. 12, Rochester, NY 14621. Seoul (Korea) 1972. Single or multi-specialty group, partnership. Available July 1980.

Rajan Jairam, M.D., 114 Franklin St., Apt. 2E1, Morristown 07960. Kasturba, Mangalore (India) 1972. Board eligible. Single or multi-specialty group, partnership. Available August 1980.

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Ambalavanar Somaskanda, M.D., 4002 Yeager Drive, Nimitz Village, Great Lakes, IL 60088. University of Ceylon (Sri Lanka) 1967. Board eligible. Single or multi-specialty group, partnership, or solo. Available August 1980.

Robert A. Stern, M.D., 7 Balint Drive, Apt. 128, Yonkers, NY 10710. New York Medical 1976. Partnership, single or multi-specialty group. Available July 1980.

ONCOLOGY—Dinesh N. Patel, Antoinette Place, Apt. 111-E, Indianapolis, IN 46227. Baroda (India) 1972. Also, general internal medicine. Board eligible (IM). Partnership, single or multi-specialty group, institutional, solo. Available July 1980.

OPHTHALMOLOGY—Jay R. Rowes, M.D., 6144 Park Avenue, Indianapolis, IN 46220. Cornell 1976. Board eligible (IM). Solo, partnership, single-specialty group. Available December 1981.

Arthur N. Landau, M.D., 327 East 58th Street, New York, NY 10022. Albert Einstein 1975. Solo, partnership, single-specialty group. Available July 1980.

Melvyn H. Defrin, M.D., 1889 Camberley Circle, Memphis, TN 38138. SUNY-Stony Brook 1975. Board eligible. Single-specialty group, partnership, solo. Available July 1980.

Paul R. Singer, M.D., 2160 Pheasant Run, St. Louis, MO 63043. University of Rochester 1973. Board certified. Single or multi-specialty group, solo. Available June 1980.

Jeffrey L. Oberman, M.D., 5600 Munhall Road, Pittsburgh, PA 15217. Albany Medical 1976. Board eligible. Partnership, single-specialty group, solo. Available July 1980.

Aly Sergie, M.D., 1815 Greenwich Woods Drive, Apt. 33, Silver Spring, MD 20903. Aleppo 1973. Solo, single-specialty group, partnership. Available July 1980.

Teofil B. Kulyk, M.D., 435 East 70th Street, New York, NY 10021. CMDNJ 1976. Board eligible. Solo, partnership, sin-

gle-specialty group. Available July 1980.

Robert F. Stephens, M.D., 502 Woodside Ave., Narberth, PA 19072. Washington University 1971. Board eligible. Partnership, single or multi-specialty group. Available July 1980.

Frederick A. Isaacs, M.D., 1234 Midland Avenue, Bronxville, NY 10708. New York Medical 1976. Board eligible. Single-specialty group, partnership, solo. Available July 1980.

OTORHINOLARYNGOLOGY—Howard Taylor, M.D., 1560 North Sandburg Terrace, Apt. 3408, Chicago, IL 60610. Columbia 1976. Board eligible. Single-specialty group, partnership, solo. Available July 1980.

Jeffrey M. Adelglass, M.D., 12 East 86th Street, New York, New York 10028. Guadalajara 1975. Board eligible. Partnership, solo, single-specialty group. Available July 1980.

David Ahmadi, M.D., 436 E. 69th Street, New York, NY 10021. Tehran (Iran) 1968. Subspecialty, head and neck surgery. Board eligible. Multi-specialty group, administrative, partnership, solo. Available July 1980.

Didier L. Peron, M.D., 2 Crest Avenue, Larchmont, NY 10538. Paris 1969. Special interest, otology. Single or multi-specialty group, partnership, solo. Available July 1980.

PEDIATRICS—Raksha J. Gajarawala, M.D., 36 Everett Road, Demarest 07627. N.H.L. (India) 1967. Board eligible. Group or partnership. Available.

Asha N. Madia, M.D., 5015 S.W. 9th Street, Apt. #97, Des Moines, IA 50315. Seth G.S. (India) 1970. Board eligible. Clinic practice. Available.

Masoud Ahdieh, M.D., 69-49 44th Avenue, Woodside, NY 11377. Tabriz (Iran) 1972. Multi-specialty group, institutional, emergency room. Available July 1980.

Mohammed H. Nomaan, M.D., 856 W. Nelson Street, Apt. 501, Chicago, IL 60657. Khyber (Pakistan) 1976. Board eligible. Institutional, multi-specialty group, partnership, research, public health or school health. Available July 1980.

Mohammad Yusuf, M.D., 7367 Hardscrapple Drive, Apt. C, St. Louis, MO 63123. King Edward (Pakistan) 1975. Multi-specialty group, institutional, solo, emergency room. Available July 1980.

Wijepala Kottahachchi, M.D., 37 Judson Street, Apt. 10-B, Edison 08817. University of Ceylon (Sri Lanka) 1969. Partnership, single-specialty group, solo. Available July 1980.

Walayat A. Khan, M.D., P.O. Box 634, Graceville, FL 32440. King Edward (Pakistan) 1971. Board eligible. Solo, emergency room. Available January 1980.

Dhanireddy Ramasubbareddy, M.D., 212 Congressional Lane, Apt. T-2, Rockville, MD 20852. Kurnool Medical (India) 1974. Any type practice. Available July 1980.

Dipak S. Banker, M.D., 436 E. 69th Street, Apt. 1-D, New York, NY 10021. G.S. Medical (India) 1971. Subspecialty, hematology. Board certified. Solo, partnership, single or multi-specialty group. Available July 1980.

Alan R. Rushton, M.D., 181 Hotchkiss Grove Road, Branford, CT 06405. University of Chicago 1977. Single or multi-specialty group, institutional. Available July 1980.

Bernard L. Lipman, M.D., 8261 Temple Road, Philadelphia, PA 19150. Univ. of South Carolina 1939. Special interest, pediatric allergy. Board certified. School health, institutional. Available January 1980.

S. Rajaram, M.D., 24 Wendy Lane, Charleston, SC 29407. Stanley Medical (India) 1969. Board eligible. Group, solo, partnership, government. Available February 1980.

R. Veluswamy, M.D., 450 West End Avenue, Apt. 5, North Plainfield 07060. Madras (India) 1973. Board eligible. Institutional, solo, group, partnership. Available July 1980.

Mark S. Ginsburg, M.D., 73-02 263rd Street, Glen Oaks, NY 11004. Medical College of Ohio 1977. Single or multi-specialty group, partnership. Available July 1980.

Martin M. Fisher, M.D., 264-10 74th Avenue, New Hyde Park, NY 11004. Einstein 1975. Board eligible. Partnership, multi-specialty group, institutional. Available July 1980.

Gita S. Sikand, M.D., 721 Westwood Drive, Apt. 2-B, Clayton, MO 63105. All-India 1972. Special interest, hematology. Board certified. Partnership, multi-specialty group, institutional. Available July 1980.

Augusto Pimazoni-Netto, M.D., Rua Jose Getulio 78 Aclima Cao, CEP, Sao Paulo, Brazil 01509. University of Sao Paulo, 1965. Administrative, industrial. Available January 1981.

PEDIATRIC HEMATOLOGY/ONCOLOGY—Sudhakar S. Chagavath, M.D., 110-52 63rd Drive, Forest Hills, NY 11375. G.S. Medical College (India) 1971. Board certified (pediatrics). Any type practice. Available July 1980.

PHYSICAL MEDICINE/REHABILITATION—Jeffrey A. Brustein, M.D., 777 Pelham Road, Apt. 2-B, New Rochelle, NY 10805. Creighton 1976. Partnership, group, solo. Available July 1980.

Aaron M. Levine, M.D., Box 2128-2111 Holly Hall Drive, Houston, TX 77054. University of Pittsburgh 1971. Institutional, research, solo. Available July 1980.

Dinesh C. Shah, M.D., 334 83rd Street, Brooklyn, NY 11209. M.P. Shah (India) 1969. Institutional, multi-specialty group, solo, emergency room. Available July 1980.

PSYCHIATRY—Marc Rothman, M.D., Presidential Apts., Apt. C-822, City Line and Presidential Blvd., Philadelphia, PA 19131. SUNY-Upstate 1976. Board eligible. Group, partnership, hospital. Available July 1980.

Jean P. Marachi, M.D., 1251 Boulevard, New Haven, CT 06511. University of Miami 1975. Board eligible. Special interest, child psychiatry. Partnership, institutional, research. Available September 1980.

Melvin W. Cohen, 681 Clarkson Avenue, Brooklyn, NY 11203. Meharry 1968. Board certified. Institutional, multi-spe-

cialty group, research. Available July 1980.
John F. McGrail, M.D., 1819 Russet Drive, Cherry Hill 08003. University of Ottawa 1961. Board certified. Single or multi-specialty group, partnership. Available June 1980.

PULMONARY MEDICINE—Leonard Sonne, M.D., 191 Beacon Street, Boston, MA 02116. New York Medical 1974. Also general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1980.

Michael Falkowitz, M.D., 245-20 Grand Central Parkway, Bellerose, NY 11426. SUNY-Downstate 1975. Also general internal medicine. Board certified (IM). Group, partnership, or hospital-based setting. Available July 1980.

David L. Kamelhar, M.D., 160 East 27th Street, New York, NY 10016. NYU 1974. Also general internal medicine. Board certified (IM). Group, partnership, or hospital. Available July 1980.

Frederick E. Cosco, M.D., 10 Waterside Plaza, Apt. 3-J, New York, NY 10010. Georgetown 1974. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

Thomandram S. Sekar, M.D., 100 Tremont Street, Apt. 1, Brighton, MA 02135. Stanley (India) 1970. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, institutional. Available July 1980.

RADIOLOGY—Anil G. Desai, M.D., 701 Red Bank Avenue, Apt. G-10, Woodbury 08096. Special interest, diagnostic radiology and nuclear medicine. Baroda (India) 1972. Board certified. Partnership, single or multi-specialty group. Available July 1980.

Thomas R. Fitzsimons, M.D., P.O. Box 73, Hellertown, PA 18055. Penn State 1973. Special interest, diagnostic radiology. Board certified. Partnership, single or multi-specialty group. Available July 1980.

Arunugam Ramasubramaniam, M.D., 430 East 67th Street, Apt. 8-J, New York, NY 10021. Madras (India) 1970. Board eligible. Any type practice. Available.

Hariprasad P. Kurella, M.D., 590 Flatbush Avenue, Brooklyn, NY 11225. Sri Venkateswara 1971. Board certified. Group, partnership, solo. Available.

Robert S. Nuba, M.D., 73-23 210 Street, Bayside, NY 11364. Guadalajara 1975. Special interest, diagnostic radiology. Single or multi-specialty group, partnership. Available July 1980.

RHEUMATOLOGY—Christopher J. Lynch, M.D., 130 Stanton Court West, Pittsburgh, PA 15201. Cornell 1975. Also general internal medicine. Board certified (IM). Solo, group, partnership. Available July 1980.

Richard D. Gordon, M.D., 37 Outlook Drive, Apt. 31, Worcester, MA 01602. Also, general internal medicine. Board certified (IM). Single or multi-specialty group, partnership. Available July 1980.

SURGERY, CARDIOVASCULAR—Louis T. Kanda M.D., 12000 Edgewater Drive, Lakewood, OH 44107. George Washington 1970. Special interest, thoracic surgery.

Board certified (general surgery). Group, partnership, institutional. Available August 1980.

Naweed K. Majid, M.D., Box 85, USAF Hospital, Wiesbaden, APO, New York 09220. King Edward (Pakistan 1967. Special interest, thoracic surgery. Board certified (general surgery). Partnership, single or multi-specialty group. Available August 1980.

SURGERY, GENERAL—Sahibzada A. Ahmed, M.D., 501 Sixth Street, Apt. 3-J, Brooklyn, NY 11215. Dacca (Bangladesh) 1970. Board eligible. Solo, group, hospital-based. Available July 1980.

F. Wesner Fleurant, M.D., 103 Gail Drive, New Rochelle, NY 10805. Haiti 1959. Special interest, vascular surgery. Board certified. Group, association, partnership, institutional, industrial, solo. Available.

Louis-Joseph Auguste, M.D., 192-15B 64 Circle, Apt. 1-B, Fresh Meadows, NY 11365. Port au Prince, Haiti 1973. Special interest, abdominal surgery. Research, institutional, multi-specialty group. Available July 1980.

Asif Husain, M.D., 56 Anderson Avenue, Englewood Cliff 07632. Dow (Pakistan) 1973. Special interest, general practice. Board eligible. Single or multi-specialty group, solo. Available July 1980.

Hardas Rathod, M.D., 4985 Hawaiian Terrace, Cincinnati, OH 45223. Baroda (India) 1970. Partnership. Available July 1980.

Ranvir S. Achreja, M.D., 2400 Southloop West, #1502, Houston, TX 77054. MGM Medical (India) 1969. Board eligible. Solo, single or multi-specialty group. Available January 1980.

Gary G. Wind, M.D., 6202 Singleton Place, Washington, DC 20034. Temple 1970. Special interest, colon and rectal surgery. Board certified. Single or multi-specialty group, research. Available July 1980.

Joseph Dotan, M.D., 1206 East 49th Street, Brooklyn, NY 11234. Hebrew University (Israel) 1966. Special interest, oncology. Board eligible. Multi-specialty group, research, partnership. Available July 1980.

Ronald H. Sultan, M.D., 7750 Roosevelt Boulevard, Eden Roc Apt. 216, Philadelphia, PA 19152. NYU 1973. Special interest, abdominal surgery. Board eligible. Partnership, solo, single-specialty group. Available July 1980.

Nirmal E. Pathak, M.D., 324 Seminole Drive, Montgomery, AL 36117. N.R.S. Medical (India) 1963. Board certified. Any type practice. Available August 1980.

Michael S. Weingarten, M.D., Henry Ford Apartments, 1350 W. Bethune Av., Apt. 1207, Detroit, MI 48202. Columbia 1974. Board eligible. Single or multi-specialty group, partnership. Available July 1980.

SURGERY, NEUROLOGICAL—Syed J. Shahid, M.D., 157 Corbin Place, Brooklyn, NY 11235. Dow Medical (Pakistan) 1972. Single or multi-specialty group, solo. Available February 1980.

SURGERY, ORTHOPEDIC—Elliot N. Lang, M.D., 356 Central Avenue, Scarsdale, NY 10583. Temple 1975. Board

eligible. Solo, group, partnership. Available July 1980.

Philip D'Ambrosio, M.D., 4 Maple Drive, Apt. 5-L, Great Neck, NY 11021. Georgetown 1976. Group. Available July 1980.

William Stratford, M.D., 16 Bennett Village Terrace, Buffalo, NY 14214. SUNY-Buffalo 1975. Solo, partnership, single-specialty group. Available July 1980.

Lewis Preschel, M.D., 104-40 Queens Boulevard, Forest Hills, NY 11375. SUNY-Downstate 1975. Board eligible. Partnership. Available July 1980.

SURGERY, PLASTIC—Donald F. Clukies, M.D., 681 Richardson Road, Rochester, NY 14623. Upstate (Syracuse, NY) 1973. Special interest, head and neck surgery. Board eligible (general surgery). Partnership, single or multi-specialty group. Available July 1980.

SURGERY, THORACIC—Louis T. Kanda, M.D., 12000 Edgewater Drive, Lakewood, OH 44107. George Washington 1970. Board certified (general surgery). Group, partnership, institutional. Available August 1980.

Khalid Y. Khan, M.D., 8 Gulf Lane, Galveston, TX 77550. King Edward (Pakistan) 1970. Also, general surgery. Board eligible (general surgery). Solo, institutional, single-specialty group. Available July 1980.

SURGERY, UROLOGICAL—Richard Kroll, M.D., 16 Pick Avenue, Fort Leavenworth, KS 66027. Albany, New York 1972. Board eligible. Partnership or single-specialty group. Available July 1980.

Steven H. Paletsky, M.D., 841 Ridgeview Drive, Medina, OH 44256. Med. U. of SC 1973. Board eligible. Partnership, solo, single-specialty group. Available January 1980.

Marc B. Osias, M.D., 12205 Morocco, NE, Albuquerque, NM 87111. Yale 1972. Board eligible. Partnership, single or multi-specialty group. Available July 1980.

William A. Mandour, M.D., 149 Elm Drive, Rochester, NY 14609. Loyola-Stitch 1974. Partnership, single or multi-specialty group. Available August 1980.

Harry F. Reiss, M.D., 2100 East Chester Road, Apt. 2-K, Bronx, NY 10461. Guadalajara 1973. Board eligible. Single or multi-specialty group, partnership. Available July 1980.

Sidney Goldfarb, M.D., 305 E. 24th Street, New York, NY 10010. Einstein 1975. Single or multi-specialty group, partnership, solo. Available June 1980.

UROLOGY—Yih-Wen Lai, M.D., 4219 Oakcrest Drive, Lorain, OH 440583. Taipei (Taiwan) 1964. Board eligible. Solo, group, partnership. Available.

Talal Samhan, M.D., Good Samaritan Hospital, Cincinnati, OH 45220. Mosul (Iraq) 1972. Partnership, institutional, group, solo. Available July 1980.

Eugene De Salvo, M.D., 400 Rutherford Boulevard, Clifton 07014. CMDNJ 1975. Solo, partnership, group. Available July 1980.

Daniel P. Wiener, M.D., 3226 Steuben Avenue, Bronx, NY 10467. Einstein 1974. Board eligible. Group, solo, partnership, academic P/T. Available July 1980.

214th Annual Meeting Medical Society of New Jersey May 10-13, 1980

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Greetings from Israel

September 25, 1979

Dear Dr. Krosnick:

Again—a message from your man in Jerusalem.

I find no dull moments living and working in the Holy Land. I do miss from time to time my old friends in South Jersey, but we have many visitors, and they keep renewing my contract here, so what can I do. Not everyone can find a new job with 95 percent involvement in his hobby, so I am grateful.

I want to thank the Society for keeping my name on its membership list.

A few months ago I was elected to the International Academy of Aviation and Space Medicine. There are only 250 members and it is considered a select group. I was certainly very lucky to have been elected, and I hope that this brings credit to my old New Jersey State Medical Society and to the State of Israel.

I would again like to extend our invitation to any visiting members to please contact me if they should be traveling in the area. We would be pleased to show them around Jerusalem.

A very happy New Year to you and the membership and say a special "hello" for me to Arthur Bernstein.

(signed) Milton Gordon, M.D.

Civil Air Surgeon—State of Israel
Box 4079—16 Rehov Sokolov, Apt. 11
Jerusalem, Israel

Maternal Mortality

October 22, 1979

Dear Doctor Krosnick:

Thank you for publishing the article on "Maternal Mortality" in the October issue of the State Journal (*J Med Soc NJ* 76:735-737). Originally we intended to run a series of articles concerning the revamping of the maternal mortality review process. Included among these was

the article by Doctors [Leah Z.] Ziskin, [Margaret] Gregory and [Michael S.] Kreitzer, detailing the revamped case detection program that they have instituted. Although I included this article among my references, I don't believe I specifically gave the credit due to Doctor Ziskin and Doctor Gregory who participated most actively in the Committee's deliberations. Since their article was recently published in another journal, and the summary was not acceptable for publication, may I take this opportunity to inform you, as Editor, of the noteworthy contributions of Doctors Ziskin and Gregory and the cooperation of the State Department of Health.

(signed) James P. Thompson, M.D.

Maimonides and Shahn

October 11, 1979

Dear Dr. Krosnick:

I should like to second Dr. Pinsky's appreciation of your August editorial (76:569). Ben Shahn's portrait of Maimonides on *The Journal's* cover and your beautiful recognition of the great modern artist and the great medieval philosopher-physician make the August issue a very remarkable one.

Some of your readers may be interested in the connection between the portrait of Maimonides and the *Ecclesiastes* inscription; "Vanity of vanities; all is Vanity" seems to have little relevance to the life and work of Maimonides. Shahn was fascinated by both themes. The head of Maimonides appears on a drawing and a watercolor as early as 1954, where the watercolor shows the philosopher holding a book with the more appropriate quotation "Teach thy tongue to say I do not know and thou shalt progress." It appears again in a very similar portrait with the same quotation as a detail of a large watercolor "Apotheosis" in 1956.

In 1965 the first of two versions of *Ecclesiastes* illustrated by Ben Shahn was published by the Spiral Press, in a limited edition of 285 copies. It was printed in black and sepia and contained three drawings by Shahn which were engraved in wood by Stefan Martin. The frontispiece is the head which you reproduced on your cover, with the Hebrew quotation, but without the title "Maimonides" and Stefan Martin's signature at the bottom. This version portrays the Preacher, although the head is that previously identified as Maimonides. The version on your cover, with the Hebrew quotation from *Ecclesiastes* and the "Maimonides artists proof V Stefan Martin inc. imp." as the bottom line, was first published as a posthumous edition of 100 copies and five artist's proofs in 1970.

In 1968 Ben Shahn handlettered and illustrated another version of *Ecclesiastes* which was published by the Trianon Press, Paris. In his foreword, Shahn stated that his infatuation with this book probably went back to his very early childhood.

"When I grew up and was drawing and painting, I became enchanted with the language of *Ecclesiastes*, reexamined it and felt an overwhelming urge to celebrate its particular way of celebrating the Lord. I did a number of watercolors, often lettering under them such wonderful lines as 'wherefore I perceive that there is nothing better than that a man should rejoice in his own works, for that is his portion; for who shall bring him to see what shall be after him?'"

"Remembering and re-reading these lines, I am suddenly struck with a sense of revelation and ask myself whether that may not actually be the reason why I am an artist."

We may speculate that the use of the portrait of Maimonides, the philosopher, to represent *Ecclesiastes*, the pious sceptic, indicates an identification of their thinking in Shahn's mind. However, this is not the place for such speculation; it is more fitting to be grate-

ful that Shahn chose to celebrate *Ecclesiastes* and Maimonides in his own way.

Do your readers know of any other connections between Ben Shahn and medicine? Kenneth W. Prescott's standard work *The Complete Graphic Works of Ben Shahn* (New York, The New York Times Book Company, 1973) mentions a portrait of Abraham Lincoln commissioned by Charles Pfizer & Co. for the cover of the company magazine *Pfizer Spectrum* and an advertising in-

sert in *JAMA* (1955, 157:19-30). Prescott does not mention the portrait of Voltaire commissioned by Eli Lilly and Company for the cover of *Physicians' Bulletin*, Volume XXVII, Number 1, March 1962. This has above the head of Voltaire, the calligraphed quotation in Shahn's inimitable lettering:

"Nothing is more estimable than a physician who, having studied Nature from his youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit

it, exercises his art with caution, and pays equal attention to the rich and the poor."

This portrait, with the calligraphed inscription but without the signature "Voltaire" or any other title or identification appears in Shahn's *Love and Joy about Letters* (New York, Grossman Publishers, 1963) as page 61.

Thank you again for your August issue which prompted this letter.

(signed) A. Arthur Sugerman, M.D.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

15 Topic To Be Announced

6 p.m., Cocktails, dinner
8 p.m., Presentation—Ramada Inn, Clark
(*NJ State Society of Anesthesiologists and AMNJ*)

MEDICINE (includes Family, Internal, and General Medicine and Dermatology)

Jan.

2 Endocrinology Dinner Meeting

6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)

2 Endocrinology Series

11:30 a.m.-1 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange

(*Endocrinology Section of AMNJ*)

2 Colitis

10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)

2 Medical Lecture Series

16 1-3 p.m.—Christ Hospital, Jersey City
23 (*Christ Hospital and AMNJ*)

30

2 Advances in Medicine

9 9:30-11 a.m.—Bergen Pines County Hospital, Paramus
23 (*Bergen Pines County Hospital and AMNJ*)

30

2 Growth Hormone in Health and Disease

16 Acute Gastrointestinal Hemorrhage
23 Management of Poisonings
30 Evaluation of Chest Pain
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

2 Endocrine Conferences

9 3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
30 (*Endocrinology Section of AMNJ*)

2 Medical Lecture Series

9 1-2:30 p.m.—VA Medical Center, Lyons
16 (*VA Medical Center and AMNJ*)

23

30

7 Diverticular Disease of the Colon

21 Hemorrhagic Shock
28 Hypertrophic Gastritis
4:30-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

8 Dermatological Office Surgery

8-10 p.m.—Schering Corporation Kenilworth
(*New Jersey Dermatology Society*)

8 Hematology

11 a.m.—Greystone Park Psychiatric

Hospital
(*AMNJ*)

9 Laboratory Interpretations

1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)

9 Musculo-Skeletal Pain

9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

10 Management of Hypertension

8-9 p.m.—Garden State Community Hospital, Marlton
(*Burlington Co. Medical Society and AMNJ*)

12 Diabetes and ENT

8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)

15 Indications for Mini-Heparin

12 noon—St. Mary's Hospital, Orange
(*AMNJ*)

16 Pulmonary Tuberculosis in Adults

11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)

16 Management of Cardiac Arrhythmias

1-4 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

16 Pulmonary Disease Topic

No time given—VA Medical Center, East Orange
(*AMNJ*)

16 Percutaneous Coronary Artery Dilation

30 Infections in Community Hospitals
9:30-11:30 a.m.—Riverside Hospital, Boonton
(*Dover General, Riverside and St. Clare's Hospitals and AMNJ*)

- 17 Treatment of Cardiac Arrhythmias**
9:30-11 a.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)
- 17 Cardiac Rehabilitation**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 18 Clinical Immunology**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 21 Immunology in Cancer**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- Guest Lectures**
- 21** 3-4 p.m.—Middlesex General Hospital, New Brunswick
- 22** 8-9 a.m.—St. Peter's Medical Center, New Brunswick
(*Nephrology Society of NJ and AMNJ*)
- 30 Acute Renal Failure**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)
- Feb.**
- 5 Infectious Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 6 Thyroid Diseases**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)
- 6 Cardiac Rehabilitation**
11:30 a.m.-1 p.m.—Rahway Hospital
(*AMNJ*)
- 6 Endocrinology Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
- 6 Endocrinology Series—Grand Rounds**
11:30 a.m.-1 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 6 Medical Lecture Series**
13 1-2:30 p.m.—VA Medical Center, Lyons
20 (*VA Medical Center and AMNJ*)
27
- 6 Endocrine Conferences**
13 3:30-5 p.m.—Rotates between Newark
20 Beth Israel Medical Center, College
27 Hospital, Newark and VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 6 Medical Lecture Series**
13 1-3 p.m.—Christ Hospital, Jersey City
20 (*Christ Hospital and AMNJ*)
27
- 6 Advances in Medicine**
13 9:30 a.m.-11 a.m.—Bergen Pines County
20 Hospital, Paramus
27 (*Bergen Pines County Hospital and AMNJ*)
- 6 Common Office Skin Problems**
13 **Nutrition in Clinical Practice**
20 **Classification of Headaches**
27 **Advances in Cardiological Diagnosis**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital, AMNJ and AAFP*)
- 9 Upper Respiratory Infections**
- 16 Physical Medicine—Pain and Disability**
8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)
- 12 Immunofluorescence in Dermatologic Diagnosis**
8-10 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 13 Low Back Pain**
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)
- 13 Medical Lecture Series**
20 1-3 p.m.—Christ Hospital, Jersey City
27 (*Christ Hospital and AMNJ*)
- 19 Laboratory Interpretations**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 19 Vasodilator Therapy in Cardiology**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 19 Glucose Monitor**
7 p.m.—Irvington General Hospital
(*AMNJ*)
- 20 An Update of Respiratory Control**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 21 Testis, Bladder and Prostate Cancer**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 27 Mitral Valve Disease**
9:30-11:30 a.m.—Riverside Hospital, Boonton
(*Riverside, Dover General, St. Clare's Hospitals and AMNJ*)
- NEUROLOGY/PSYCHIATRY**
- Jan.**
- 2 Child Psychiatry Case Conference**
9 8:30-10:30 a.m.—Trenton Psychiatric
16 Hospital
23 (*Trenton Psychiatric Hospital and*
30 *AMNJ*)
- 3 Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive, South Orange
(*Advanced Psychiatric Study Group and AMNJ*)
- 3 Psychiatric Lecture Series**
10 11 a.m.-12 noon—Greystone Park
17 Psychiatric Hospital
24 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 7 Lecture Series**
8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminars and AMNJ*)
- 7 Neuroscience Conferences**
14 11:30 a.m.-12:30 p.m.—Bergen Pines
21 County Hospital, Paramus
28 (*Bergen Pines County Hospital and AMNJ*)
- 8 Psychiatric Case Conferences**
15 7:30-9:30 a.m.—Trenton Psychiatric
22 Hospital
29 (*Trenton Psychiatric Hospital and AMNJ*)
- 8 Seminar on Law and Psychiatry**
15 3:30-5:30 p.m.—Rutgers Law School,
22 Newark
29 (*Rutgers Law School and AMNJ*)
- 9 Grand Rounds in Psychiatry and Mental Health Science**
23 1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 9 Use of Meditation and Hypnosis**
- 16 Behavior Therapy-Inpatient Uses**
- 23 Management of the Problem Drinker**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 9 Musculo-Skeletal Pain**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 10 Psychotherapy Schizophrenia**
- 17 Use of Positron Emission Tomography in Study of Cerebral Metabolism**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 16 Presence of Endogenous Morphinemimetics**
1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 16 Special Problems in Neurology**
7-9:30 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 16 Milieu Therapy**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)
- 22 Hypertension**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 23 Multiple Sclerosis**
4-5 p.m.—Kessler Institute, West Orange
(*Kessler Institute for Rehabilitation and AMNJ*)
- 29 Current Chemotherapy**
2 p.m.—Ancora Psychiatric Hospital
(*AMNJ*)
- Feb.**
- 4 Anorexia Nervosa-Twenty Years Later**
8-10 p.m.—39 Crescent Ave., Passaic
(*Essex Psychiatric Seminary and AMNJ*)
- 4 Neuroscience Conferences**
11 11:30 a.m.-12:30 p.m.—Bergen Pines
18 County Hospital, Paramus
25 (*Bergen Pines County Hospital and AMNJ*)
- 5 Psychiatric Case Conference**
12 7:30-9:30 a.m.—Trenton Psychiatric
19 Hospital
26 (*Trenton Psychiatric Hospital and AMNJ*)
- 6 Distinguished Speakers Series**
20 1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 6 Psychiatric Lecture Series**
13 1-3 p.m.—Ancora Psychiatric Hospital
20 (*Ancora Hospital and AMNJ*)
- 6 Ongoing Child Psychiatry Case Conference and Lecture**
13 8:30-10:30 a.m.—Trenton Psychiatric
20 Hospital
27 (*Trenton Psychiatric Hospital and AMNJ*)
- 7 Narcissism, Sleep and the Dream**
8:30 p.m.—Hackensack Hospital
(*NJ Psychoanalytic Society and AMNJ*)

**THE THIRD ANNUAL
EDWARD G. WATERS
GYNECOLOGIC CONFERENCE**

Presented by the Department of Obstetrics and
Gynecology of the New Jersey Medical School—CMDNJ
at Resorts International Hotel, Atlantic City, New Jersey.

**WORKSHOPS on April 10, 1980
GYNECOLOGY CONFERENCE on April 11-13, 1980**

For further information, please contact Herik Caterini,
M.D., Department of Obstetrics and Gynecology, New
Jersey Medical School, 100 Bergen Street, Newark, New
Jersey 07103. (201) 456-6480.

CONTINUING EDUCATION CREDITS:

	Workshops April 10	Conference April 11-13
AMA Credits Category I:	5	20
ACOG Cognates:	5	17
AAFP Prescribed Credits:	5	17
AOA Credits Category 2-D:	5	16
NJSNA Credit Hours:	5	20 (pending)

- 7 Improving Psychotherapeutic Techniques**
8-10 p.m.—312 Harding Drive,
South Orange
(*Advanced Psychiatric Study Group and AMNJ*)
- 7 Psychiatric Lecture Series**
14 11 a.m.-12 noon—Greystone Park
21 Psychiatric Hospital
28 (*Greystone Park Psychiatric Hospital and AMNJ*)
- 13 Psychiatric Syndromes in Medical Disease**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 13 Grand Rounds in Psychiatry and Mental Health Science**
27 1:30-3 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 20 Special Problems in Neurology**
7-9:30 p.m.—VA Medical Center,
East Orange
(*VA Medical Center and AMNJ*)
- 20 Confidentiality (Privileged Communication)**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)
- 23 Pediatric Head Injuries**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)
- OBSTETRICS/GYNECOLOGY**
Jan.
- 2 Lectures in Obstetrics/Gynecology**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 2 Grand Rounds in Ob/Gyn**
9 3-5 p.m.—Rotates between CMDNJ-
16 College Hospital, Newark Beth Israel
23 and St. Michael's Medical Centers,
30 Newark, St. Joseph's Hospital and
Medical Center, Paterson, and Jersey
City Medical Center
(*CMDNJ and AMNJ*)
- 3 Grand Rounds in Ob/Gyn**
10 4-5 p.m.—College Hospital, Newark
17 (*CMDNJ and AMNJ*)
- 24**
31
- Feb.**
- 6 Lectures in Obstetrics and Gynecology**
8-10 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 6 Combined Grand Rounds in Ob/Gyn**
13 3-5 p.m.—Rotates between CMDNJ-
20 College Hospital, Newark Beth Israel
27 and St. Michael's Medical Centers,
Paterson and Jersey City Medical Center
(*CMDNJ and AMNJ*)
- 7 Grand Rounds in Obstetrics and Gynecology**
14 4-5 p.m.—College Hospital, Newark
21 (*CMDNJ and AMNJ*)
- 28**
- PATHOLOGY**
Jan.
- 8 Pathology Lectures**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 8 Renal Biopsy Conferences**
12:30-2 p.m.—Barnert Memorial
Hospital Center, Paterson
(*Barnert Memorial Hospital and AMNJ*)
- Feb.**
- 12 Renal Biopsy Conferences**
12:30-2 p.m.—Barnert Memorial
Hospital, Paterson
(*Barnert Memorial Hospital and AMNJ*)
- PEDIATRICS**
Jan.
- 5 Tumors of Bone and Soft Tissue in Children**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)
- Feb.**
- 5 Meningitis in Pediatrics**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 23 Pediatric Head Injuries**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)
- RADIOLOGY**
Jan.
- 9 Neuro-Radiology Meeting**
7:45-10:15 p.m.—Morristown Memorial
Hospital
(*Radiological Society of NJ and AMNJ*)
- 16 Radiotherapy Section Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(*Radiotherapy Section, AMNJ*)
- 17 Topic to be announced**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for Northern NJ and AMNJ*)
- Feb.**
- 21 Topic to be announced**
7:15-10:15 p.m.—Hospital Center at
Orange
(*Diagnostic Radiology Section for Northern NJ and AMNJ*)
- 13 Neuro-Radiology Meetings**
7:45-10:15 p.m.—Morristown Memorial
Hospital
(*Morristown Memorial Hospital and AMNJ*)
- GENERAL SURGERY**
Jan.
- 7 Distinguished Lecture Series in Surgery and Grand Rounds**
21 4:30-5:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 8 Surgical Lecture Series**
5-6 p.m.—Rutgers Medical School,
Piscataway
(*CMDNJ and AMNJ*)
- 8 Tumor Conferences**
15 11 a.m.-12 noon—Morristown
Memorial Hospital
22 (*Morristown Memorial Hospital and AMNJ*)
- 18 Tumor Conference**
12 noon-1 p.m.—Elizabeth General
Hospital
(*Elizabeth General Hospital and AMNJ*)
- 19 Abdominal Surgery**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)
- Feb.**
- 4 Distinguished Lecture Series in Surgery and Grand Rounds**
11 4:30-5:30 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 5 Surgical Lecture Series**
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Dr. Samuel Blaugrund

At the grand age of 86, Samuel Blaugrund, M.D., a well-known Trenton physician, died in Mercer Medical Center on October 17. A graduate of Jefferson Medical College, class of 1915, Dr. Blaugrund pursued a career in pediatrics and had been chief of that department at Mercer Medical Center for many years. He was a Fellow of the American Academy of Pediatrics and had been chairman of the New Jersey division. Dr. Blaugrund was active in Medical Society affairs, serving on the old Welfare Committee and chairing the Committee on Child Health. He also had been chief of the Maternal and Child Health Division of the City of Trenton's health department. In 1965 Dr. Blaugrund was a recipient of MSNJ's Golden Merit Award indicating 50 years of practice.

Dr. Arthur J. Casselman

At the grand age of 91, an emeritus member of the Camden County Medical Society, Arthur J. Casselman, M.D., died on September 11. Dr. Casselman was graduated from the University of Pennsylvania Medical School in 1911 and practiced general medicine in the Gibbsboro area for many years. He had been affiliated with Camden County General Hospital and was director of the county public health laboratory. He was a member of the American Public Health Association and the American Society of Clinical Pathologists. In 1961 Dr. Casselman was a recipient of MSNJ's Golden Merit Award. He had been in poor health and retired in 1960. Dr. Casselman currently was living in Haddonfield.

Dr. Fred J. Crescente

Fred J. Crescente, M.D., a member of our Passaic County component, died on September 28 at Paterson General Hospital. A native of Haskell, Dr. Crescente

was graduated from Georgetown Medical School, class of 1932, and pursued a career in general surgery with special interest in gynecologic surgery. He was senior attending surgeon at Paterson General Hospital. Dr. Crescente had many interests outside the medical profession. He was on the board of directors of the Paterson Boys Club, a physician for the New Jersey State Boxing Commission, and a former owner of the New York Titans football team. He was a Fellow of the American Academy of Obstetrics and Gynecology and of the International College of Surgeons. Dr. Crescente was 79 years old at the time of his death.

Dr. R. T. deHellebranth

Roland T. deHellebranth, M.D., a well-known Atlantic County physician, who operated a private hospital in Ventnor for surgical and obstetric patients, died in Graduate Hospital, Philadelphia on October 19. Born in Budapest (Hungary) in 1901, Dr. deHellebranth was graduated from the Royal Hungarian University in 1923 and took graduate studies in Vienna and Paris before coming to the United States in 1925. He was a Fellow of the American Society of Abdominal Surgeons. Dr. deHellebranth retired from active practice in 1970 and was a recipient of MSNJ's Golden Merit Award in 1973, indicating 50 years of contribution to medicine.

Dr. Joseph M. Fiorello

A member of our Mercer County component and former Trenton practitioner, Joseph M. Fiorello, M.D., died at his home in Florida on October 28. A native of Trenton, born in 1922, Dr. Fiorello was graduated from Jefferson Medical College in 1952 and practiced in Trenton and Loveladies for 22 years before moving to Fort Lauderdale, Florida where he maintained a family practice. He was board certified in family

practice and a Fellow of the American Academy of Family Physicians. Dr. Fiorello had been affiliated with St. Francis and Helene Fuld Medical Centers in Trenton before moving to Florida where he was chief of the family practice section at the North Ridge General Hospital in Fort Lauderdale.

Dr. Thomas S. P. Fitch

On October 15 one of Union County's senior members, Thomas S. P. Fitch, M.D., died at his home. Born at the turn of the century, Dr. Fitch was a graduate of Columbia University's College of Physicians and Surgeons in 1925 and had practiced neurosurgery in the Plainfield area until retirement in 1970. He was a Fellow of the American College of Surgeons and a diplomate in neurosurgery. Dr. Fitch had been on the staff at many area hospitals: Muhlenberg, Newark Eye and Ear, Somerset, Middlesex General, St. Peter's, Elizabeth General, and the Veterans Hospital at Lyons. During World War II, he served in the medical department of the U.S. Navy. Dr. Fitch had been active in Medical Society affairs and was a member of the state society's Judicial Council for many years.

Dr. Howard M. Freas

One of Monmouth County's senior members, Howard Malcolm Freas, M.D., died in Riverview Hospital, Red Bank on August 30, following a cerebrovascular accident. Born in 1895, Dr. Freas was graduated from the University of Pennsylvania Medical School in 1921 and took internships at Mercer Hospital in Trenton and Lankenau Hospital in Philadelphia. He was a medical missionary in the Belgian Congo from 1925 to 1955. Upon returning to New Jersey, he established a general practice in West Orange and was a member of the Essex County component before

moving to Red Bank in 1976. Dr. Freas was a member of the American Public Health Association and of the Royal Society of Tropical Medicine. In 1971 he was a recipient of MSNJ's Golden Merit Award, honoring his fifty years of practice.

Dr. J. Leonard Greif

A member of our Morris County component, J. Leonard Greif, M.D., of Dover, died on October 14. A native of Virginia, Dr. Greif was graduated from New York Medical School, class of 1936, and followed a career in otolaryngology. He was a Fellow of the American College of Surgeons and of the International College of Surgeons and certified by the American Board of Otolaryngology. He had been on the staff at St. Clare's Hospital in Denville as attending plastic surgeon, and at Dover General Hospital as attending surgeon specializing in head and neck surgery. Dr. Greif was a member of the American Academy of Ophthalmology

and of the American Academy of Plastic Surgeons. During World War II he served in the medical Department of the U.S. Army.

Dr. Thomas F. Lynch

Thomas F. Lynch, M.D., a family practitioner in Bergen County, died on October 15. A native of New Jersey, born in 1910, Dr. Lynch was graduated from New York Medical College, class of 1937, and had practiced in Teaneck for many years. He had been affiliated with Holy Name Hospital in Teaneck. During World War II, Dr. Lynch served in the medical department of the Army of the United States.

Dr. Elliot Rinzler

On October 18, Elliot Rinzler, M.D., a member of our Essex County component, died at his home. Born in 1914 and graduated from New York University Medical School, class of 1937, Dr. Rinzler pursued graduate studies in

otolaryngology (becoming board certified in that specialty) and later in neurosurgery. He had been affiliated with Martland, Eye and Ear, Presbyterian, St. James and Children's Hospitals in Newark, and with the Clara Maass Hospital in Belleville. During World War II Dr. Rinzler served in the medical department of the AUS.

Dr. Philip Solomon

We just have learned of the death on September 1st of Philip Solomon, M.D., a member of our Essex County component. Born in 1916 and graduated from the medical school of the University of Syracuse, class of 1941, Dr. Solomon pursued a career in obstetrics and gynecology and was board certified in that field. He was a Fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons. He had been affiliated with Newark Beth Israel and Irvington General hospitals, and with St. Barnabas Medical Center in Livingston.

BOOK REVIEWS

How To Improve Your Child's Behavior through Diet

Laura J. Stevens and Rosemary Stoner. Garden City, NY, Doubleday, 1979. Pp. 346. (\$9.95)

A parent using this book will find a compilation of anecdotal experiences together with an extensive set of recipes and instructions for managing a large variety of elimination diets. The former lacks validity; the latter has pragmatic utility. One regrets the gullibility of the authors, who propose to treat such conditions as water retention, seizures, paranoia, school phobia and dyslexia by dietary manipulation. One admires their perspicacity, and the real utility of their instructions for managing these diets. It is regrettable that the authors could not have investigated what little productive research into the effects of diet on behavior we have, such as the careful work of Kinsbourne or Connors. It would have been wonderful if the authors could have

used their energy to stimulate productive research in this area, thereby possibly helping some children and sparing others innumerable tests, large expenditures and years of unpleasant dietary restriction and manipulation. The authors would do well to heed the words of Claude Bernard, writing over 100 years ago: "Scientific medicine . . . can be established only by experimental means . . . (the) application of reasoning to the facts furnished us by observation and experiment." A. L. Katcher, M.D.

Ophthalmic Plastic Surgery for the General Ophthalmologist

Murray A. Meltzer, M.D. Baltimore, Williams and Wilkins, 1979. Pp. 84. Illus. (\$18.95)

This is a small volume in which the author has selected his favorite operations for some common oculoplastic problems. It makes no pretense of being

a fully comprehensive text, but it offers the benefit of the author's experience and his choice of oculoplastic repair.

It is too sketchy to be of use as a text for teaching, but it might be of value to those ophthalmologists who do occasional oculoplastic surgery.

J. H. White, M.D.

B. A. Maltzman, M.D.

The Truth About Senility—And How To Avoid It

Lawrence Galton. New York, Thomas Y. Crowell Company, 1979. Pp. 244. (\$9.95)

This book is encyclopedic in its scope and has the impact, for the physician, of the flash of a safety match. For the lay reader, who obviously was the target of the sensational title, the book is an agglomeration of quotes, reports, and references. In fifteen chapters and 244 pages the author deals with just about all conditions which can disturb the homeostasis of the elderly. An indication of

the author's penchant for the sensational is the fact that he discusses "macular disease" in eleven lines and devotes three pages to the "Great Imposter"—temporo-mandibular joint dysfunction. He should start his reading with *Webster* who defines senility as "quality or state of being senile"—just old.

David Eckstein, M.D.

Accreditation Manual for Hospitals

1980 Edition. Joint Commission on Accreditation of Hospitals. Chicago, JCAH, 1979. Pp. 225. (\$20)

The first complete revision of the manual since 1970, the 1980 edition contains revised governing body, hospital-sponsored ambulatory care services, management, and administrative services, nursing services, and utilization review standards. These revised standards become effective for accreditation purposes on January 1, 1980.

The section on "Quality Assurance" is meant to replace Standard I of the Quality of Professional Services section of the 1970 Accreditation Manual for Hospitals, and the numerical requirements for audit specified in Appendix B of that edition. Because this section represents a "new approach" to quality assurance, it is not to be implemented for accreditation decision purposes at this time.

While no physician will want to buy this manual, any of us interested in having his/her hospital accredited has a vital interest in its contents; and will undoubtedly be exposed to its "requirements." It is interesting to realize that this is a voluntary request for accreditation and the cost is borne by the requesting hospital. Another example of the masochistic endeavors of the medical profession. V. H. Boogdanian, M.D.

Skin Deep: The Making of a Plastic Surgeon

Donald T. Moynihan, M.D. and Shirley Hartman. Boston, Little, Brown & Co., 1979. Pp. 339. (\$10)

Written primarily for the lay public and not for the medical doctor, *Skin Deep* offers a realistic look into the fast-growing specialty of plastic surgery. Doctor Moynihan, with the literary assistance of Shirley Hartman, who co-authored *The Surgeons* with Walter Ellerbe, M.D., bases his real-life story upon a diary he kept during his two-year residency in a metropolitan teaching

hospital. The demands, the challenges and the triumphs involved in training a plastic surgeon are presented in an accurate, realistic, behind-the-scenes viewpoint and in a story that reads like a novel.

Doctor Moynihan presents the psychological changes that occur as well as describing in detail the physical transformations that take place with cosmetic as well as reconstructive surgery. As the story and his residency develop, a variety of plastic surgical procedures are described including mammoplasties, rhinoplasties, otoplasties, hand surgery, repair of cleft palates, scar revisions, dermabrasion, hair transplants, transsexual surgery, the treatment of burns, head and neck surgery, and others. The authors skillfully include accurate detail while utilizing language that the layman can understand. Considerable attention is given to the psychological implications as well as to the risks and the realistic expectations of plastic surgery and the enhancement of the patient's self-image.

Personal empathy is felt when Doctor Moynihan describes his own reactions to discovering that his own two-year-old son has a rhabdomyosarcoma. Doctor Moynihan believes the experience of witnessing his son's treatment has made him a better doctor and a better human being.

Skin Deep would be helpful reading for the medical student or the young surgeon who is considering becoming a plastic surgeon. One might change his mind or become even more determined to overcome the obstacles and meet his goal.

Raymond B. Strauss, M.D.

Conference on Recertification

Evanston, Illinois, American Board of Medical Specialties, 1978. Pamphlet—pp. 124. Limited complimentary copies available.

This small paperback pamphlet summarizes a conference held in 1978 by the American Board of Medical Specialties. The text presents the reasoning and methodology of each of the examinations for recertification by each of the sub-specialty boards as well as the Board of Internal Medicine and the American Academy of Family Practice. Question and answer periods follow each presentation. Future plans for those Boards that have not given any examinations as yet also are presented.

Methods of grading the results of each

of the examinations and what they mean to the Boards that have given them all are discussed. CME and the states that demand this for relicensure are evaluated by Dr. Derbyshire. The non-boarded physician has not been overlooked. Examinations are also in his or her future.

My feelings about the conference are summarized by Dr. Albert R. Jonsen: "Principally, I would interpret what I heard in terms of self interest because I heard a message running through the entire day which told me that you do not know what you are doing." You "do not know the validity of this, we do not know its reliability . . . we don't know how much information we ever get about the one crucial thing: namely, performance"; . . . nor will it "protect the consumer." We need some method of measuring quality practice and quality assurance which none of these examinations does. We are spending too much time in evaluation and not enough time on the real substance of the practice of medicine. At the rate we are going it probably will take a few generations to come up with the right answers to this knotty problem. A. Bernstein, M.D.

Current Surgical Diagnosis and Treatment, 4th Edition

J. Englebert Duffy, M.D. and Lawrence W. Way, M.D. Los Altos, CA, Lange, 1979. Pp. 1162. Illus. (\$19)

The fourth edition of this surgical text makes available in concise form the basic information and the most recent developments in general surgery and in each of the surgical specialties. The Table of Contents for the 1162-page book includes all subjects found in the standard contemporary textbooks of surgery. However, the subject matter is updated clearly and succinctly in one-half the space. The inclusion of an appendix with normal values and conversion tables is a welcome feature.

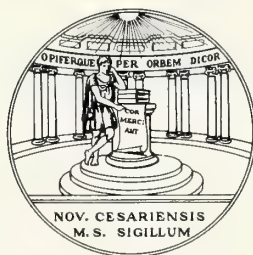
The chapters on the anorectum and otolaryngology have been completely rewritten, and the neurosurgery chapter is substantially revised. New information has been added to all chapters, and the bibliographies have been updated. The book has been completely reset in a larger and more readable typeface.

The book has a soft cover and the holding capacity of the binding is doubtful. It is ideal for a medical student or surgical resident and would fit into a "concise" medical library for a practitioner.

Stanley S. Fieber, M.D.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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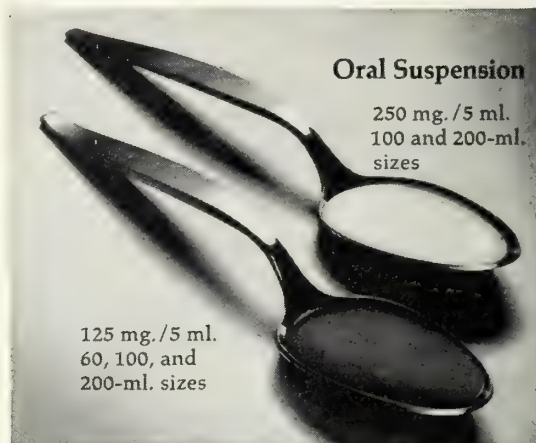
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979 House of Delegates

213th ANNUAL MEETING

The Medical Society of New Jersey

May 12–15, 1979

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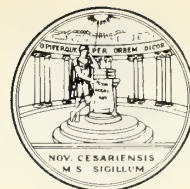
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July Transactions 1979

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1978 Transactions

At its first session on Saturday, May 12, 1979, the House of Delegates approved the Transactions of the 1978 House of Delegates as published in the July 1978 Transactions issue of *The Journal*, and the Transactions of the Special Session of the House of Delegates held December 10, 1978, as published in the January 1979 issue.

Action To Limit Debate

At its first session on Saturday, May 12, 1979, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four (4) minutes unless exception is made by the House. This was limited to two (2) minutes for the Tuesday morning (May 15) session.

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MEMORIAL RESOLUTIONS

The following resolutions were received by the House with sorrowful concurrence.

Sigurd W. Johnsen, M.D. 1895-1978

Whereas, the Supreme Author has summoned our beloved colleague, Sigurd W. Johnsen, M.D.; and

Whereas, as a Fellow and Officer of the Medical Society of New Jersey, Doctor Johnsen served the members of this Society and the people of New Jersey; and

Whereas, by his dependability and consideration he won the esteem of all who knew him; now therefore be it

RESOLVED, that the Medical Society of New Jersey records its lasting indebtedness to Sigurd W. Johnsen, M.D., and its heartfelt grief at his passing; and be it further

RESOLVED, that this Resolution be spread upon the minutes of this meeting and that a copy, suitably prepared, be presented to his bereaved family in token of our sympathy.

Emanuel M. Satulsky, M.D. 1909-1978

Whereas, Almighty God has summoned from our midst His good servant and our beloved colleague, Emanuel M. Satulsky, M.D.; and

Whereas, as a Fellow of the Medical Society of New Jersey, a member of the Board of Trustees, a member of the AMA Delegation, a member of the AMA Council on Constitution and Bylaws, a member of the Judicial Council of the Medical Society of New Jersey and numerous other councils and committees of the Medical Society of New Jersey, Doctor Satulsky rendered uniformly high and valuable service to the Medical Society of New Jersey and the

people of our State; and

Whereas, by his industry, understanding, and dependability he won the respect and esteem of all who knew him; now therefore be it

RESOLVED, that the Medical Society of New Jersey, honoring Emanuel M. Satulsky, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this Resolution be spread upon the minutes of this meeting and another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

The following resolutions were received without referral to committee.

Resolution of Commendation

From the Essex County Medical Society

Whereas, Frank J. Hughes, M.D., retired as Chairman of the New Jersey Delegation to the American Medical Association; and

Whereas, Doctor Hughes has served the Medical Society of New Jersey in an outstanding manner with exemplary dedication for many years as a Delegate to the AMA; now

therefore be it

RESOLVED, that the Medical Society of New Jersey commend Doctor Frank J. Hughes for his dedicated service to medicine and the community, and for his leadership at both the state and national levels of organized medicine.

Adopted by acclamation without referral to committee.

Walter L. Pannell, M.D.

From Herman M. Robinson, M.D., Essex County

Whereas, Walter L. Pannell, M.D., of East Orange, will celebrate his one hundredth birthday this July; and

Whereas, Doctor Pannell has been a faithful member of the Essex County Medical Society and the Medical Society of New Jersey for more than fifty years; and

Whereas, Doctor Pannell is still an honored and valuable

consultant in the field of ear, nose, and throat disease; now therefore be it

RESOLVED, that the House of Delegates of the Medical Society of New Jersey honor Doctor Pannell for his long and loving service to his patients and his continued support of his fellow physicians.

Adopted by acclamation without referral to a committee.

Gift to MSNJ

From the Ocean County Medical Society

Whereas, the Medical Society of New Jersey has seen fit to leave Trenton; and

Whereas, they have departed a charming old period home; and

Whereas, the Medical Society of New Jersey has acquired a new structure with miles of plain walls; and

Whereas, it is appropriate to relieve this plainness and

suggest a note of beauty and continue the thoughts of the outside world; now therefore be it

RESOLVED, that the Ocean County Medical Society present this original painting in the hope of relieving the aforesaid need; and be it further

RESOLVED, that this action may stimulate other county societies to similar thoughtful actions.

Accepted with appreciation.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

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Reports:
Committee on Revision of
Constitution and Bylaws
Amendment to Bylaws

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

The 1978 House of Delegates adopted the following substitute resolution, which was referred to the Committee on Revision of Constitution and Bylaws for preparation of the necessary amendment to the Bylaws:

RESOLVED, that the Medical Society of New Jersey adopt a membership policy that requires membership in the American Medical Association.

BYLAWS

CHAPTER XI—Component Societies

Section 2—Qualifications of Members

Current

Proposed

(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.

(a) Same

(b) To be eligible for membership, the applicant must:
(1) be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners;
(2) be legally registered under that license in a county of New Jersey;
(3) be of good moral and ethical standing; and
(4) not support, or practice, or claim to practice any exclusive system of medicine.

(b) Same

(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall

(c) Same

forward the name and address of the applicant to the biographic department of the American Medical Association for such information as may be on file relative to the applicant's record.

(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials.

(d) Same

(e) In order to retain active membership in this Society the member must hold a current Certificate in Continuing Medical Education from the Medical Society of New Jersey's Committee on Medical Education. This Certificate will be bestowed upon members who complete acceptable programs of continuing education for a total of 150 hours in a given three-year period. This program is to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates. The Committee on Medical Education may, with the approval of the Board of Trustees, and for good cause shown, grant specific exemptions to this subsection.

(e) Same

(f) *In order to retain active membership in this Society a member also must hold membership in the American Medical Association.*

The Committee on Constitution and Bylaws recommends adoption of this proposal.

Not Adopted—Reference Committee recommendation had been for adoption.

REFERENCE COMMITTEE "A"

**Ralph J. Cavalier, Jr., M.D., Atlantic
Chairman**

Roger C. Laauwe, M.D., Passaic

Aris M. Sophocles, M.D., Mercer

Harry W. Fullerton, Jr., M.D., Salem

James J. O'Grady, M.D., Essex

Victor H. Boogdanian, M.D., Middlesex

Alternate Member

Reports:

President

Board of Trustees

Secretary

Judicial Council

Executive Director

Committee on Credentials

Committee on Long Range

Planning and Development

**Resolutions #1, #2, #3, #4, #5,
#6, #7, #31, #33**

President

Charles S. Krueger, M.D., Mount Holly

(Reference Committee "A")

My year is past and the problems and events have been such that the Medical Society of New Jersey has responded in a way in which all members can be proud. Ours is the single organization truly representing all physicians in New Jersey. We are over 9,000 strong. Our opinions are sought on all medical matters coming before the public. Your leadership has responded positively and aggressively, addressing the problems which we feel will affect the better health of our patients and the public at large. It is of utmost importance that our general membership know how we have acted and it is through this House of Delegates that I hope we can provide this information and exert positive leadership.

Our membership has remained stable in spite of increasing dues. We still need to better our numbers in the AMA, especially if we are to go into unified membership with the AMA this coming year. Our dues remain lower than average for the country and it is anticipated that there will be no raise this year.

We are dropping some members from our Society who have not completed their continuing medical education requirements. Fortunately, this is only a very few. It is important to note that the State Board of Medical Examiners has chosen not to make this a requirement for State licensure because of our action.

Our new home in Lawrenceville is now a reality. Though not yet completed, enough has been done so that we all can be proud of our new facility. It is not only a good investment, but will allow us to support functions "at home," long overdue. We have the capacity to hold the House of Delegates in our headquarters' building, so we now should give strong consideration for a fall-winter interim session.

The single most important area now confronting us is the increasing involvement of government in the private practice of medical care. It is understandable because the dollars spent on medical care are increasing at a rate which is now over eight percent of the national budget. Inflation has made the public sit back and take notice and now, for the first time in many years, and perhaps ever, there is a general awareness that there is a limit on what we can spend and on the amount we wish to be taxed. Americans want the best medical care in the world but now realize that this comes at a price which is dear to all of us. We are willing to spend more on health but,

in order to do this, there must be sacrifice. If the government is going to continue to increase its spending, it is logical that taxes must be increased in order to support this. Many Americans realize that less seems to be returned from Washington compared to what goes down. It is in this atmosphere that we are finding ourselves almost in an adversary position with government, and it is in this atmosphere that discussion about national health insurance is taking place.

I had the opportunity this past year to observe firsthand the National Health Service in Britain and the National Health System in Canada. Their doctors have fared generally well. Of course, no one is getting rich, but the general impression is one of moderate content with their systems. Both countries have social systems that offer additional compensations, so that dollar-for-dollar income comparison is difficult to perceive. There is little professional satisfaction in their medical practice and an outsider is struck immediately by their low productivity. In addition, they work fewer hours and, therefore, patients are forced into long lines and thus the long wait for elective medical care and surgery. The British emergency system is excellent, but this is where it ends. There is no longer pride in medical practice and the private initiative in individual medical services has disappeared.

The American public is running scared. They are frightened of the rising cost of medical care and possibly their inability to afford it. Catastrophic illness is just what the word implies, but the fear is not of medical catastrophe, but of financial catastrophe. We must offer answers. We must agree to work on some type of health-care coverage which responds to this most pressing problem.

We must convince the public that we have their concerns uppermost in our minds and that, when in a public forum, we don't appear to be self-serving. For some time, I have felt that a doctor who is satisfied, who has taken great pride in his services, who is compassionate, and, yes, financially rewarded, is much better in offering his services to patients. Any system which tries to take away this freedom quickly becomes inferior, and in the end would be completely unacceptable in this country.

Our government leaders, I believe, are well aware of this.

The leadership of your Society has been in discussion numerous times this past year with our government representatives in this State, as well as in Washington. I personally had several discussions with Representative Paul Rogers, and even spent an evening with one of our greatest adversaries, Joseph Califano. I believe we have had some degree of influence on hospital cost-containment policies as well as that of certificate of need.

A government-controlled health care system as proposed by Kennedy and others is completely unacceptable to us. We agree that there are a significant number of people without adequate health insurance coverage in this country, but this is not to say that our whole system must be disrupted to include these people in a total coverage system. Alternatives must be offered to cover this significant minority, however, and we must come up with ways to correct this injustice, preserving the best parts of our present system.

In January, your Board of Trustees appointed an ad hoc committee to develop a position paper on national health insurance to present to the AMA for their presentation to Congress. It contains four important points:

(1) Minimum standards of adequate health benefits should be required of all insurance policies sold in the United States, with appropriate deductible and coinsurance.

(2) A simple system of uniform benefits should be provided by government for those unable to provide for themselves.

(3) Catastrophic insurance through private carriers, with government supplement when necessary, should be standard for all.

(4) Administration of the above programs should be at the state level.

Because financial awareness and incentives are becoming so important, we must look to alternative health care delivery systems. New Jersey is second only to California in the number of HMOs, the prepaid health care system developing in our country. Most of us are uncomfortable with these closed panel systems, but the open panel HMOs or independent practice associations (IPAs) may offer the best of both worlds. It has been of concern to me that physicians are being blamed for the increase in medical cost while receiving less and less of the total health care dollar. It has been shown that HMOs might reduce the total cost of health care, and, additionally, change the percentages of this health care dollar from 60 to 40 in favor of hospitals to 60 to 40 in favor of physicians. It is time we sit up and take notice of what these alternative health care delivery systems can do, while the choice is still voluntary. The free market system competing for the health care dollar is by far more attractive to me and I believe acceptable to the American public, compared with a government handout with all its controls and regulations, and increased taxes.

Our New Jersey Foundation for Health Care Evaluation presently is exploring the feasibility of a statewide fee-for-service HMO, contrasting with regional county(ies) IPAs. It appears attractive to me and presents a full-care system to the public which contains the free choice and quality of our present system, along with the financial incentives and cost-containment options so necessary at this time. I hope we will study it carefully and participate if it proves viable. The Foundation needs our full support to develop it.

Two of our biggest problems this past year revolved around the new Public Law 94-484, which severely restricts the number of foreign-born foreign medical graduates entering the mainstream of medical practice in this country. The

New Jersey Department of Higher Education and others see this as a real threat to the physician supply in our State. There is ample support for this because recently the number of FMGs has amounted to over 70 percent of the newly licensed physicians, with only 10 percent of these being American born. We also have the dubious distinction of having the greatest relative number of FMGs in our residency programs. This, of course, has not been all that bad. However, in future years, it is estimated that because of the restrictive nature of PL 94-484 our new physician supply will be severely curtailed. Because of this, there has been considerable impetus, through proposed legislation, to allow the physician's assistant to practice in this State. Also, the College of Medicine and Dentistry of New Jersey plans to increase the physician output of our medical school system through the building of the osteopathic medical school in southern New Jersey.

The basic premise of increasing the output of medical school graduates to 400 per year is a good one. Our Society, however, has expressed great concern over the means by which this is to be accomplished. We want good schools to evolve and it seems that the College of Medicine and Dentistry of New Jersey wants to set up a new basic science facility in southern New Jersey before fully utilizing its present structures in Newark and Piscataway. It concerns us that the proposed clinical facilities have not been tested fully and that a full four-year medical school, freestanding, and osteopathic, is being proposed. It has taken over 15 years to develop our own present medical schools at Newark and Rutgers, and they still are not considered in the highest ranks of comparable medical schools. In the School's defense, we realize they have more than their share of minority students, and for this they must be praised. We do feel, however, that the development of an additional school should move more slowly and deliberately, for it is feared we will have an inferior medical education system.

I have presented position papers to the New Jersey Commission on Professional Health Services and to an ad hoc committee of the Department of Higher Education, concerning the above problems of medical education. As of this writing, the question of medical education in southern New Jersey is still up in the air, but a decision should be forthcoming in April. Your Society has been sensitive to the needs of the people and physicians in this State, and especially to the physicians in South Jersey.

It appears we have won the first battle opposing physicians' assistant legislation in New Jersey. This past Fall, after considerable study and discussion, I personally had felt that we had no chance of defeating this legislation and that our best form of attack was to give the legislation conditional approval, requesting additional restrictive amendments. These amendments were accepted. It became increasingly apparent, however, that this House of Delegates had great concern about physicians' assistants and that our Society should continue active opposition. This House stated the quality of medical care would suffer, there would be no reduction in the cost of medical care, and there was no demonstrated need. It was also felt that even though the proposed legislation is very restrictive, it would be a "foot in the door," allowing future independent practice and thus creating another problem we would have to come to grips with.

The Statewide Committee to Seek Support to Opposition of Physicians' Assistant Legislation, made up of presidents and presidents-elect of the five largest county medical socie-

ties, must be given high marks, along with the keyman system, because they were able to influence enough legislators to vote in the negative when the physicians' assistant legislation was initially brought to the floor on February 26. It was through their gallant effort, along with our excellent lobbying system, that we were able to defeat the initial vote on this bill. Another vote, however, is forthcoming and we must not sit back and rest on our laurels, for, even though the initial battle has been won, the war is not yet over.

Many other events have transpired this past year. Our Governor threatened the Medical Society with a lawsuit, charging restraint of trade when we proposed to *not* bill for our services to Medicaid patients, thereby causing our State not to qualify for federal support. Partly because of this and the difficulty in implementation, the Board of Trustees chose not to carry out the intent of the resolution of the 1978 House.

Our Medicaid Committee continues to be very active, meeting monthly with representatives of the Division of Medical Assistance and Health Services, which has control over Medicaid matters. A fair reimbursement fee is still the major problem and one with which we are not satisfied. We now are receiving less than 50 percent of our customary fee, and for a family practitioner this barely covers the overhead. Because of this Committee's activity, progress is being made regarding the differential in the fee for a patient's visit to a hospital clinic and to a physician's office.

We have had our problems with the Department of Health which seems to be becoming more and more involved in the private practice of medical care. It has proposed an excellent system regionalizing emergency medical services, which, in some areas, has been something long needed in this State. It has, however, overlooked the voluntary system now in operation quite successfully in many areas, and the voluntary ambulance people feel they have been bypassed in this new system. Input from our Society has not been utilized fully, and we are concerned about implementation of the new system. Also, the cost is considerable.

The certificate of need for large hospital expenditures seems to be working properly in most regions. We severely have questioned its application to private physician offices. The Department of Health would do well to go very slowly in this area as we do not feel it has the right to control private enterprise when it does not involve the hospital or the third party payment system.

We can be proud of our malpractice insurance company, the Medical Inter-Insurance Exchange of New Jersey and the New Jersey State Underwriters. It is considered among the finest in the country. I have had the opportunity to sit in at Board deliberations and continually have been impressed

with its leaders and staff. The overall premium for the company has been reduced this year, but some of the groups in the high-risk, and one in the low-risk group, the pediatricians, by class change have had their premiums remain unchanged. The pediatricians feel that their class change was rather abrupt, but the increasingly bad experience in this group has indicated that actuarially this was a sound decision. Their specialty society believes the Medical Society was not completely sensitive to their needs because of the lower average income of this group and, hopefully, in the future when a class change or premium increase is indicated the group, or groups, will be contacted prior to submission of these changes to the Insurance Commissioner. Additionally, we hope by increased participation in risk management and physician education that our malpractice experience will decrease and that our premiums will be further reduced.

Finally, this has been a year of achievement for me. It also has been one of frustration—frustration because of the multitude of problems. A single year in this position is just not long enough to become knowledgeable and adept at handling all of them. The staff support from the Medical Society has been superb. We are blessed with the finest. The general membership also must be complimented for its increasing participation in Medical Society matters.

Further, consideration should be given for a full-time president who might have the option of being elected year after year if he or she should prove worthy of merit, so perhaps some of my frustrations would be answered. The problem with this, as I see it, would be that we might lose the benefit of having a president no longer in private practice and, thus, losing touch with the feelings of the general membership.

I do think it is important, however, that all of you realize one can be president of this Society, be active in Medical Society matters, and still carry on a full, active, private medical practice. Individual effort must be made in order to carry this out. I have been blessed with two partners in my general surgical practice who have allowed me to be available by giving of their services to my practice so that I might be free at a moment's notice. I must praise these two partners by name. I commend Doctors Lindley B. Reagan and Rodolfo C. Pascual for being the two finest men that one could ever hope to work with. I could not have served the presidency without them.

This year has been the pinnacle of my life. It has been rewarding. I never would have thought the honor would be mine coming into New Jersey just thirteen years ago. I hope my success will stimulate others to strive for similar achievements for it is only with strong representative leadership that we can hope to survive.

Filed in accordance with the recommendation of the Reference Committee.

Board of Trustees

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "A")

Once again, it is my privilege and duty to report on the activities of the Board of Trustees for the past year. With each passing year, the pressures on the Society seem to mount in geometric proportions, and this year was no exception. As a consequence, more elements of the Society are involved, and it is gratifying to see increasing attendance by county and specialty society presidents at the Board meetings. Unfortunately, there is a move toward developing a state society of specialty groups. One need only look at the national problems of the Council of Medical Specialty Societies and the AMA to see how divisive such a move would be. The Medical Society exists to represent physicians some of whom may be specialists. The problems of the profession as a whole eventually will affect all physicians, and further to fragment our voice into parochial groups only will dilute effectiveness of action. No specialty group will be ignored or without support if it participates meaningfully in the deliberations of our Society. It is, however, unrealistic to expect the State Society to anticipate and rectify special problems in a vacuum. With full representation and participation our ability to address common problems is magnified greatly, and the Board continues to encourage monthly involvement by all those diverse elements that constitute our Society.

To improve the ambience of our work, the Board consummated the purchase and alteration of new Executive Offices in Lawrenceville. A total package of two million dollars, securely financed will assure continued growth in efficient and pleasant surroundings. Interestingly enough, the membership voluntarily has contributed more than \$30,000, through the Cornerstone Club, indicating firm support for this move. As development proceeds, the Medical Society, the Foundation, the Academy of Medicine, and the Medical Inter-Insurance Exchange all will be under the same roof. Adequate space remains for conference rooms, House of Delegates Hall, and future expansion.

Most frustrating during the year has been the stubborn problem of South Jersey medical education. While CMDNJ is convinced an osteopathic school with a basic science facility is necessary in Camden, using the local hospitals for allopathic training, a Coalition of Southern County Societies believes no such facility is needed. Debate has been heated and at times acrimonious, often pitting allopathic versus osteopathic philosophies. The Board believes, and has so stated, that integrated medical education is essential and that, while the needs could be met by expansion of current facilities, if new building is necessary it should be combined osteopathic and allopathic. The issues are so complex, and emotions so high, that at this writing the outcome is still uncertain.

Equally frustrating has been the issue of physician assistant legislation. Powerful forces are supporting the use of such personnel, and despite repeated polls showing support among physicians for PAs, the House of Delegates has consistently opposed them. The Board, sensing the inevitable and the value of being involved, conditionally approved current legislation suggesting amendments stringently to control assistant use.

In an emotional special session, the House reaffirmed its opposition. Despite the best efforts of the Society, it is likely

this legislation will pass and the Society will be in a compromised position in trying to maintain quality care.

Physician reimbursement at all levels continues to be a problem. Despite militant activity by some toward governmental and other third party payers, the Board believes that statesmanship and negotiation can solve this issue, perhaps somewhat more slowly, but more surely than rash opposition. Toward this end, the Council on Medical Services has been directed to produce a means of dealing with the issue more directly and innovatively.

The Society is awaiting a report from the Foundation regarding the development of a statewide IPA/HMO vehicle which will assure preservation of the private practice concept while also addressing the problem of cost containment and maintenance of quality care. Currently, multiple IPA/HMOs are developing, and the Board fears eventual controversy and conflict among these relatively small entities leading to their undoing. In regard to cost containment, through its development of a joint Medical-Hospital Cost-Containment Committee with firm recommendations, New Jersey is leading the nation toward the more effective utilization of resources and facilities. The members of the committee are to be congratulated on their dedication to a very unpopular concept. If implemented fully, their recommendations could be a real move toward more cost-effective medical care without loss of quality.

It is impossible to detail all the concerns addressed by the Board this year, but the Society should rest secure in the knowledge that no problem, no request, and no issue will be ignored. It continues to be the responsibility of the membership to participate meaningfully in the management of their Society, giving the Board the benefit of informed debate. In a vacuum the Board will be compromised. With full participation and cooperation many of our toughest problems will yield.

Filed in accordance with the recommendation of the Reference Committee.

Other activities that occupied the Board follow:

AMPHETAMINES

(Reference Committee "A")

Following the close of the 1978 Annual Meeting, Resolution #3 was forwarded to the State Board of Medical Examiners, the Attorney General, and the Deputy Attorney General.

The State Board tabled action on the Proposed Rule on Prescribing, Administering or Dispensing Amphetamines and Sympathomimetic Amines until the Division of Criminal Justice has an opportunity to review and comment on the Rule.

Filed in accordance with the recommendation of the Reference Committee.

HEALTH CARE ADMINISTRATION BOARD

(Reference Committee "A")

The Board of Trustees instructed the Executive Committee to appoint a physician to serve as the Society's representative to the monthly meetings of the Health Care Administration

Board. Daniel J. O'Regan, M.D., was appointed to serve in this capacity.

Filed in accordance with the recommendation of the Reference Committee.

HEALTH TESTING AND DIAGNOSTIC CENTERS

(Reference Committee "A")

A communication was directed to the State Board of Medical Examiners reiterating the Society's position on health testing and diagnostic centers that a patient must be referred for multiphasic health testing by a physician, with a report to the referring physician. When the physician has not so referred a patient and a report is received and opened, the physician is not to be obligated to perform professional services for that patient.

Filed in accordance with the recommendation of the Reference Committee.

HOSPICE CONCEPT

(Reference Committee "A")

The New Jersey Delegation introduced a resolution to the AMA House of Delegates urging support of the hospice concept. The AMA adopted the resolution as follows:

RESOLVED, that the AMA approve the hospice concept to enable the terminally ill to die in surroundings more homelike and congenial than the usual hospital environment; and be it further

RESOLVED, that this action be widely publicized to encourage extension of this specialized approach for the provision of terminal care.

Filed in accordance with the recommendation of the Reference Committee.

NATIONAL HEALTH INSURANCE

(Reference Committee "A")

An ad hoc committee was formed to make recommendations and prepare a position statement on the national health insurance issue. The Committee was composed of the following members: Chairman of the Board (Dr. Todd), President (Dr. Krueger), two members of the Board (Dr. Kovacs, who served as chairman, and Dr. Abrams), and three AMA Delegates (Dr. Alessi, Dr. Benz, Dr. D'Elia).

The following course of action was recommended by the Committee and approved by the Board:

That the AMA should proceed with the drafting and introduction of legislation that will embody the following principles:

(a) Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and coinsurance. (Free choice of physician/patient, and inclusion of as many of the 17 principles of the former AMA policy is indicated.)

(b) A simple system of uniform benefits provided by the federal government for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, hardship, etc.) not to be able to provide for their own medical care. (We depart from AMA policy in this section in that we do not call for state and local involvement. In our experience, such a structure produces disparate benefits, unequal and inefficient administration.)

(c) A nationwide program by the private insurance industry (with government reinsurance if necessary) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.

(d) A program developed pursuant to these principles should be administered at the state level (utilizing fiscal intermediaries) with national standardization through federal guidelines.

The Committee also considered Resolution #10, referred by the Medical Society of New Jersey's House of Delegates to the Board, which is being implemented by the foregoing action. To further the Society's position the following recommendation was approved:

That the Board of Trustees refer the booklet, "Patient Education Packet" to the Council on Public Relations, with the charge that the Council develop an effort to utilize the material either for TV spot announcements or paid air time. Once the concept is developed, requests should be made to have the Private Medical Care Foundation and the AMA underwrite the cost of distribution.

The Board noted that the above materials could be used in conjunction with the Public Relations effort on Resolution #13, 1978.

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report

The following items from the April 18 meeting of the Board of Trustees are supplied for the information of the House of Delegates.

NATIONAL HEALTH INSURANCE

(Reference Committee "A")

Supplied for the information of the Board was the following position on national health insurance, which was adopted by the AMA Board of Trustees on March 30-31, 1979:

(a) That the AMA work toward amendment of S-760 and S-748 which will, as closely as possible, bring these pieces of legislation in conformity with Resolution 62 (I-78) and the recommendations of the Council on Legislation and the Council on Medical Service to the end that the AMA position on these consolidated amended bills would be one of endorsement or support of the legislation;

(b) That lacking substantive amendments to these bills that would be agreeable to the Association, the AMA again would be in a position of opposition to the legislation;

(c) That this action be communicated to the House of Delegates by the Board, with a statement of its reasons for the action and the amendments to these bills that the AMA will seek to achieve;

(d) That the Board seek the assistance of the state, county, and medical specialty societies to effect this position;

- (e) That the Board indicate that it does not intend to call a special session of the House of Delegates at this time but call attention to the mechanism whereby the House may call a special session if it chooses;
- (f) That a steering committee be appointed, composed of the Executive Committee of the Board and the Chairman and Vice-Chairman of the Council on Legislation and the Coun-

cil on Medical Service to prepare the amendments and the communication to the House of Delegates and determine its timely distribution to the House.

Filed in accordance with the recommendation of the Reference Committee.

Secretary

Arthur Bernstein, M.D., East Orange

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1978)

Active: Paid	8,059	
Exempt	834	8,893***
*Associate Paid	1	
**Affiliate: Paid	80	
Exempt	3	
State Emeritus	536	
Total of Above	9,513	
State Honorary	8	
New and Reinstated Members:		
Active	566	
*Associate	1	
**Affiliate	4	
Change of Status	7	
Transfers within the state	35	
Transfers out of state and resignations	139	
Members deceased	119	
Members dropped:		
Active (non-payment of dues)	95	
(N.J. licensure revoked)	2	
(N.J. licensure suspended)	4	
(N.J. licensure voluntarily surrendered)	2	
*Associate (non-payment of dues)	1	
**Affiliate (non-payment of dues)	1	105

*Associate membership (non-licensed in N.J.) designates interns and residents.

**Affiliate membership designates physicians who no longer practice in New Jersey.

***Adjusted for transfers out-of-state, resignations, and deaths.

AMA MEMBERSHIP

A total of 6,242 members of the Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at seven delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

This past October production and distribution to members was completed on the 1979 edition of the *Membership Directory*.

The 1979 edition of the *Membership Directory* embodied the same features and utilized the same format as the 1976/1977 edition. Verification data sheets were used as the basis for the biographical information on the member. The innovation introduced and tested for the 1979 edition, namely the use of the toll-free telephone number for verification and updating of data, was successful but not utilized fully by the entire membership. Tentative plans at this writing are to dispense with the phone program and return to the "mail-in" program for the 1981 *Membership Directory*.

An expression of gratitude is in order for the cooperation received from the members in assisting us to produce this issue of the *Membership Directory*.

Work is being carried on for the next edition of the *Membership Directory* to be issued in the late Fall of 1980.

Filed in accordance with the recommendation of the Reference Committee.

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton

(Reference Committee "A")

The Judicial Council, which met five times during the year, presents the following resume of its operations and those of county judicial committees for the year now ending (as of April 1, 1979):

By Judicial Council

Official communications acted upon	35
Appeal hearings granted	0
Pending	1
Formal opinions rendered	1

Ethical acceptability of the release of information by a workmen's compensation treating physician upon request of the patient's attorney (Adopted January 14, 1979)

The foregoing Opinion is presented in full as Appendix #1 to this report.

By County Judicial Committees

Complaints reported as disposed of	42
Alleging:	
Dissatisfaction concerning fees	20
Dissatisfaction concerning medical procedure	12
Dissatisfaction concerning professional ethics	5
Unprofessional conduct	5

The Council is indebted to the judicial committees of the component societies for their efficiency of operation and for their conscientiousness in regularly reporting all cases accepted for adjudication at the local level and the dispositions made of them.

The Council recognizes, of course, that some judicial committees can further improve their functioning. The Council is striving—and will continue to strive—to revise and devise procedures, as necessary, to deal with all complaints promptly and effectively.

For assistance in the adjudication of complaints, the Judicial Council distributed, to all judicial committees, copies of its revised booklet of "Medical Society of New Jersey Opinions" for their assistance.

REGULATIONS

In fulfillment of its regulatory powers under the Bylaws, the Council completed a revision of the "regulations" governing the judicial mechanism. This revised version was distributed to all county societies at the Judicial Workshop held on October 22, 1978 and is presented as Appendix #2 to this report.

JUDICIAL COMMITTEES/COUNCIL ASSUMING JURISDICTION OVER COMPLAINTS OR INQUIRIES CONCERNING PHYSICIANS' FEES

The Council is aware of the activities of the Federal Trade Commission and the response of the AMA. We believe, however, that if the medical profession is to serve the public and if the profession is to be one of integrity and dedicated service to humanity, we must provide a mechanism whereby complaints or inquiries by the patients or insurance com-

panies involving ethics, professional conduct, and the reasonableness of fees of physicians can be rationally adjudicated.

The Council is, therefore, of the opinion that judicial committees must continue to hear cases questioning the reasonableness of physicians' fees.

APPENDIX #1 OPINION #26—ADOPTED JANUARY 14, 1979

Release of information by a workmen's compensation treating physician upon request of the patient's attorney.

It is the opinion of the Judicial Council of the Medical Society of New Jersey that any physician who has treated a patient is under an obligation to furnish that patient, or the patient's attorney, copies of medical records or, if necessary, specially written reports. It is reasonable that the physician charge a fee for the service involved. A photocopy of an office record might involve a fairly nominal charge. Preparation of a special report would justify a fee that would reflect the time required of the physician.

APPENDIX #2

Pursuant to the authority and responsibility vested in it under the provisions of Chapter IV of the Bylaws of the Medical Society of New Jersey, the Judicial Council of the Society does hereby promulgate the following revision of its *Fundamentals, Rules and Regulations for the Processing of Grievances and Complaints by County Judicial Committees*, effective as of June, 1978.

Fundamentals

The Judicial Council of the Medical Society of New Jersey and the judicial committees of component medical societies constitute the judicial mechanism of the Medical Society of New Jersey.

The judicial mechanism is intended to make available a means whereby differences and disagreements in the areas of ethical and professional conduct can be brought to a settlement that is fair to the interest of all parties.

Original jurisdiction concerning complaints rests with the judicial committee or committees of the component medical society or societies in which the doctor or doctors involved hold membership. Appeals from the findings of judicial committees may be taken to the Judicial Council of the Medical Society of New Jersey. Beyond the Judicial Council of the Medical Society of New Jersey, appeals may be taken by AMA members to the Judicial Council of the American Medical Association.

The House of Delegates of the Medical Society of New Jersey is the legislative body, and the Board of Trustees and the officers constitute the executive body of the Society. The Judicial Council has the plenary responsibility for the supervision and maintenance of the judicial mechanism.

The mechanism is intended to demonstrate that medicine can equitably and amicably settle its own problems in the areas of ethical and professional conduct.

The Judicial Council shares with the judicial committees

the authority to summon members of component societies to appear and testify, either in connection with the complaint involving the members summoned, or as witnesses in cases involving other members. Failure to honor such a summons shall give rise to citation of the member for contempt of the mechanism which shall subject him/her to disciplinary action by the judicial committee.

Disciplinary Powers

The decisions of the judicial committee of a component society are binding upon all members of that component society, and the judicial committee of each component society in the enforcement of its findings, duly arrived at, has the power to censure, suspend, or expel any member of its society for just cause. Likewise, if the county judicial committee or a joint county judicial committee shall find after a hearing that a complaint, allegation, or grievance involves a matter which, in its opinion, would empower the State Board of Medical Examiners to revoke or suspend the license of a practitioner, it shall be the duty of such committee forthwith, by written complaint, to refer the findings to the appropriate law enforcement agency or the State Board of Medical Examiners. *Disciplinary Sanctions* are not to be implemented until termination of the forty-five (45) day appeal period mentioned in paragraph #10 of the following Regulations.

All decisions of the Judicial Council and of the judicial committees are binding upon the respective members of MSNJ. They are not offered to members merely as advice. No member is free to decide whether or not he will conform to them. In addition, after the forty-five (45) day appeal period has expired, the judicial committees may, in their judgment, notify hospital medical staffs and other appropriate agencies, as indicated, of their findings and determinations.

Any dissatisfaction or criticism involving the judicial mechanism—by individual members or component societies—should be directed, without delay, to the Judicial Council.

The Regulations which follow are all supplementary to the Bylaws and these Fundamentals.

Addendum—Dated October 22, 1978

Rules and regulations for the processing of grievances and complaints involving members of the Medical Society of New Jersey and its component medical societies

Censure within the Medical Society of New Jersey's Judicial Mechanism generally has followed two formats:

(a) Private—Verbal criticism directed by the Judicial Committee to the defendant physician in Executive Session.

(b) Public—A report of censure to the county medical society which is read at a meeting of the county medical society and published in the minutes thereof. It also may be published in the bulletin of the given county medical society or otherwise distributed in the judgment of the Judicial Committee.

Regulations for the Processing of Grievances and Complaints

1. (a) A complaint against a member or members received by the Medical Society of New Jersey shall be referred to the Judicial Council, which in turn shall assign it to the judicial committee of the component medical society of proper jurisdiction (the component society in which the doctor or doctors complained against hold membership).

(b) A complaint against a member or members received by

a component society shall be referred immediately to the judicial committee of that component society.

2. No complaint shall be given official consideration unless it is submitted in writing, signed, and presents in full all necessary details.

3. Receipt of a complaint in proper form by a judicial committee shall be acknowledged to the complainant or complainants in writing, and the date of receipt of the complaint shall be therein noted.

4. The member or members of the component medical society against whom the complaint is lodged shall be informed, in writing, of the receipt of the complaint, the date of receipt and shall be supplied with a copy thereof.

5. The possibility of amicable settlement of the differences by means of individual contact with the parties to the complaint shall be explored by a designated member or members of the judicial committee before the complaint is officially presented to the full judicial committee for action.

6. When the complaint is not possible of such amicable settlement, and when assurance has been given by the complainant(s) that no court action is in process or contemplated, the judicial committee shall accept the complaint for processing.

7. A hearing shall be scheduled forthwith by the judicial committee, to which physician members are summoned and non-members are invited. Grievance Report Form A (supplied by the Judicial Council) shall now be completed and sent without delay to the Judicial Council of the Medical Society of New Jersey.

In the case of complaints made by third parties, the patient or patients who received the medical care rendered should also be invited to attend the hearing. However, failure of such patients to respond to such invitation shall not constitute basis for cancellation of the hearing.

Any member of the judicial committee who is a party to or who has an interest in the complaint, shall at this juncture disqualify himself from participation in the processing of the complaint.

It is advised that parties to the complaint be interviewed and interrogated separately in the course of the hearing. They may be represented at the hearing by legal or other counsel.

All evidence and testimony presented at the hearing and all discussion by the judicial committee relevant thereto shall be *confidential* to the judicial mechanism. No discussion of the complaint shall be indulged by any member of a judicial committee or of the Judicial Council except in the hearing dealing with the complaint or in the executive session following the hearing, or in fulfillment of official investigatory or judicial assignments.

8. Subsequent to the hearing and the departure of the parties to the complaint, all findings of the judicial committee shall be arrived at in executive session.

9. All principals shall be informed immediately and simultaneously of the committee's findings. This notification is to be signed by an officer of the committee and forwarded by registered or certified mail.

10. All parties to the complaint, when notified of the committee's findings, also shall be informed of their right of appeal to the Judicial Council of the Medical Society of New Jersey, from the findings of the judicial committee. The parties shall likewise be specifically informed that any appeal to the Judicial Council must be filed, in writing, within forty-five (45) days of the date of the formal notices to them of the findings of the judicial committee.

11. At the time of notification to the parties to the complaint of the findings of the committee, Grievance Report Form B shall be completed and sent to the Judicial Council of the Medical Society of New Jersey.
12. In the event that a judicial committee, either by choice or through neglect, does not hold a hearing or effect adjustment of a complaint within sixty (60) days of receipt of a complaint properly submitted, the Judicial Council shall investigate the delay and shall in its discretion recommend procedures for the effective and prompt processing of the complaint.
13. If no request for appeal is made within the specified

time, all original exhibits received in conjunction with the complaints—such as originals of prescriptions, letters, bills, etc.—shall be returned by the judicial committee of the component society to the principal or principals who submitted them.

14. Records of a county judicial committee shall be subject to inspection exclusively by members of that committee and/or its legal counsel, the Judicial Council, and its legal counsel.

Filed in accordance with the recommendation of the Reference Committee.

Executive Director

Vincent A. Maressa, Lawrenceville

(Reference Committee "A")

On December 28, 1979, the Society relocated its Executive Offices to 2 Princess Road, Lawrenceville. We still are conducting major renovations but it is anticipated that the Medical Society of New Jersey Office and Meeting Complex will be completed about May 18, 1979. Offices to accommodate the Academy of Medicine of New Jersey, and the New Jersey Foundation for Health Care Evaluation will be operational by August 1979. The Insurance Company central office will be occupied in the late Fall of 1981.

A major staff reorganization has been undertaken and should be completed by June 1, 1979. During this same period we will be moving into the computerization of the Society's main data bank and accounting procedures.

The Board of Trustees has authorized the retaining of a

management consulting firm to review and analyze staff organization and performance, as well as general society structure. Hopefully the end result will produce a cohesive bond uniting the staff, Board of Trustees, and the House of Delegates with the common goal of maximum service to the membership.

This year we have altered the format of the Conference of Presidents to include the presidents of the specialty societies, and also the presidents of the medical staffs of the various New Jersey hospitals. Hopefully with this change in format we will be able to keep the medical leadership in New Jersey well informed of Society projects and activities.

Filed in accordance with the recommendation of the Reference Committee.

Credentials

Arthur Bernstein, M.D., Chairman, East Orange

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1978 to February 28, 1979.

<i>Received:</i>	
*Associate Interns	1
*Associate Residents	2
Total Received: 513	
<i>Reviewed and Found:</i>	
(a) Satisfactory	
*Associate Interns	1
*Associate Residents	2
(b) Unsatisfactory	0
Subtotal: 431	
Active	502
Osteopaths	8

*Associate membership (non-licensed in New Jersey) designates interns and residents.

<i>Pending:</i>		
*Associate Interns	0	Active 78
*Associate Residents	0	Osteopaths 4
Grand Total: 513		

The committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members and MSNJ staff for their diligence and cooperation.

Filed in accordance with the recommendation of the Reference Committee.

Long Range Planning and Development

William J. D'Elia, M.D., Chairman, Spring Lake

(Reference Committee "A")

During the past year we considered whether or not specialty societies should be given representation in the Medical Society of New Jersey's House of Delegates.

Obviously, this is an issue which can and will become emotionally charged. It is our belief that such representation should be extended to all specialty societies in New Jersey which are affiliated with national specialty societies recognized by the AMA. The Board of Trustees has referred our report to the Committee on Constitution and Bylaws for report to the House of Delegates at a session subsequent to the 1979 Annual Meeting.

Our Statement of Goals as approved by the Board of Trustees are as follows:

STATEMENT OF GOALS

The Committee believes that if the Society is to be effective in a long-range planning and development effort it must, of necessity, look toward the goals it has set, i.e., a viable, effective association to advance the interests of the practitioners of medicine through scientific, educational, socio-economic, and legislative programs; evaluate the barriers and the means to achieving the desired goals; and implement the mechanisms to carry through to completion.

In order to reach an awareness that problems do indeed exist, and as a method of starting to deal with these problems, the Committee on Long Range Planning and Development recommends that at the Annual Meeting of the Medical Society of New Jersey the chairmen of the reference committees be charged with making a list of problems that become evident during their meetings; and that such lists be

presented to the President and to the Board of Trustees for referral to the Committee on Long Range Planning and Development and other appropriate committees for study and recommendation during the next year. The Committee will, of course, continue to study and explore areas as it deems advisable.

The Committee on Long Range Planning and Development concurs with the charges as developed by the Council on Long Range Planning and Development of the AMA which states:

"The functions of the Council on Long Range Planning and Development are:

"To study and make recommendations concerning the long-range objectives of the Association.

"To study and make recommendations concerning the projected resources, programs and organizational structure by which the Association attempts to reach its long-range objectives in the above.

"To serve as a focal point for the planning activities of the Association and to stimulate and evaluate planning activities throughout the organization.

"To study, or cause to be studied, the future environment in which medicine and the Association must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision-making centers throughout the Association, and submit reports to the House of Delegates at appropriate times."

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#1

AMA Reconsider Physician Assistant Support

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, the physician assistant program is an idea which no longer is necessary for the delivery of good medical care in this country; and

Whereas, the House of Delegates of the Medical Society of New Jersey has gone on record as overwhelmingly opposing the registration or licensure of physician assistants; and

Whereas, many states have indicated that they are having "second thoughts" on this matter; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey,~~

~~through its Delegates to the American Medical Association, ask the American Medical Association to reconsider its position on physician assistants.~~

Adopted in accordance with the recommendation of the Reference Committee, and after editorial changes by the House in the "Resolved" to read:

RESOLVED, that the Medical Society of New Jersey, by proper resolution through its Delegates to the American Medical Association, ask the American Medical Association to change its position of support for physician assistants to one of active opposition.

#2

Definition of the Term of Office of Delegates and Alternate Delegates to the American Medical Association

From the Gloucester County Medical Society

(Reference Committee "A")

Whereas, the House of Delegates of the Medical Society of New Jersey has limited the term of our AMA Delegates and Alternates to three consecutive two-year terms; and

Whereas, this action seriously limits the strength of our New Jersey Delegation, the service and experience of our *elected* New Jersey members, and is inconsistent with the terms of office of all AMA delegations from other states; and

Whereas, this limitation is inconsistent with the terms of office of our own elected state officers, trustees, and council members; and

Whereas, all Delegates and Alternates repeatedly are subject

to the democratic elective process by the House of Delegates; now therefore be it

RESOLVED, that the previous action of the House be rescinded; and be it further

RESOLVED, that AMA Delegates and Alternate Delegates be eligible to serve five consecutive two-year terms in each office upon election by this House of Delegates.

Rejected in accordance with the recommendation of the Reference Committee.

#3

Establishment of Policy to Rescind Action of the House of Delegates

From the Hudson County Medical Society

(Reference Committee "A")

Whereas, actions of the Board of Trustees regarding the physician assistants issue created an adversary relationship between the majority of the delegates and the Board; and

Whereas, unity of purpose and action is vital to the effectiveness of the Medical Society of New Jersey; and

Whereas, most delegates felt that the Board arbitrarily had overruled the duly deliberated position of the House of Delegates, without proper process; and

Whereas, the problem is essentially a matter of interpretation of the Bylaws; and

Whereas, amendment of the Bylaws would be time consuming, and might result in over-restriction of the Board of Trustees' capacity to function effectively; now therefore be it

RESOLVED, that a policy be established for procedure when the Board of Trustees believes a previous action of the House of Delegates to be no longer appropriate; and be it further

RESOLVED, that said policy shall be as follows:

A poll be taken of all currently designated delegates, specifi-

cally restricted to two questions which would be answered yes or no.

Question "A": Do you agree to rescind the present House position?

Question "B": Do you support the Board's proposed alternative?

1. If an affirmative majority be recorded to both questions, the Board of Trustees would proceed with its alternative.

2. If the poll affirmed Question "A" but rejected Question "B," a Special Session of the House of Delegates would be called.

3. If the poll rejected both questions, any change in position would be tabled until the next meeting of the House of Delegates.

Rejected in accordance with the recommendation of the Reference Committee that it would be unwieldy and would hamstring the Board of Trustees.

#4

Extension of Terms for AMA Delegates and Alternates

From the Union County Medical Society

(Reference Committee "A")

Whereas, the desire of the House of Delegates of the Medical Society of New Jersey to send younger representatives to the AMA as delegates has been achieved; and

Whereas, the current limitations effectively will prevent any AMA delegate from New Jersey from becoming a national officer; now therefore be it

RESOLVED, that the House of Delegates of the Medical Society of New Jersey authorize a bylaw change to allow

delegates and alternates a total of twelve years in office except in those cases where the *delegates* themselves recommend to the House that a specific delegate or alternate be permitted additional terms because he/she is a likely candidate for national office.

Adopted in accordance with the recommendation of the Reference Committee. Note: Requires change in MSNJ Bylaws for implementation.

#5

Gas Rationing for Health Personnel

From George L. Benz, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, some system of gas rationing will need to be developed because of an anticipated fuel shortage; and

Whereas, physicians, nurses, and other health professionals require sufficient amounts of gasoline to attend properly to patient needs; and

Whereas, health professionals must commute to hospitals, skilled nursing facilities, and homes for the aged, etc.; and

Whereas, many primary care physicians have patients who must be seen at home and in more than one nursing home and hospital; and

Whereas, many specialists have patients in many different hospitals and institutions who must be seen on a daily basis and in emergency situations; and

Whereas, the amounts of gasoline to be made available under the present rationing plan may be adequate for office personnel that commute to one business site or institution,

they would be inadequate for physicians and other health care personnel to provide patient care services; now therefore be it

RESOLVED, that the Medical Society of New Jersey go on record that physicians, nurses, and other health professionals be allocated sufficient gasoline adequately to take care of patient needs; and be it further

RESOLVED, that the Medical Society of New Jersey contact all departments of government at the state level that are concerned with fuel energy rationing to effectuate these aims; and be it further

RESOLVED, that the New Jersey Delegates to the AMA be instructed to draft a similar resolution for presentation at the next meeting of the AMA House of Delegates so that these goals may be attained at the national level.

Adopted in accordance with the recommendation of the Reference Committee.

#6

National Health Insurance

From the Board of Trustees

(Reference Committee "A")

Whereas, an ad hoc committee was created by the Board of Trustees to consider Resolution #10 (1978) which was referred to the Board by the House of Delegates; and

Whereas, that ad hoc committee, recognizing the intense pressure on the Congress for a national health insurance program, believes that organized medicine should participate

in the development of that federal legislation; now therefore be it

RESOLVED, that the Medical Society of New Jersey House of Delegates support the introduction of federal legislation that embodies the attached concepts.

Concepts To Be Embodied in National Health Insurance Legislation

- Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and coinsurance. (Free choice of physician/patient, and inclusion of as many of the 17 principles of the former AMA policy is indicated.)

- A simple system of uniform benefits provided by the federal government for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, hardship, etc.) not to be able to provide for their own medical care. (We depart from AMA policy in this

section in that we do not call for state and local involvement. In our experience, such a structure produces disparate benefits, unequal and inefficient administration.)

- A nationwide program by the private insurance industry (with government reinsurance if necessary) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.

- A program developed pursuant to these principles should be administered at the state level (utilizing fiscal intermediaries) with national standardization through federal guidelines.

Rejected. The recommendation of the Reference Committee had been for adoption.

#7

National Health Insurance and Catastrophic Health Insurance

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the AMA House of Delegates on December 5, 1978 adopted the following resolution:

"Whereas, it is a recognized fact that Americans have the best medical care and delivery system in the world today, and most polls indicate the public is generally satisfied with both the quality and quantity of medical services; and

"Whereas, the polls have consistently reflected that the American people hold their individual physician in higher regard and trust than any other professional; and

"Whereas, it is this very personal doctor-patient relationship that will be dismantled and ultimately destroyed by national health insurance; and

"Whereas, the primary thrust for a nationalized, socialized system of medical care has continuously come from a political arena where logic is often lacking; and

"Whereas, at this time, it would be unwise for organized medicine, at any level, to sponsor or support federal legislation to further nationalize or socialize physicians' services in this country; and

"Whereas, there is a need to improve our present system—not by discarding or disregarding our present one; now therefore be it

"RESOLVED, that the American Medical Association recommend to the Congress of the United States of America modifications to our present health care system embodying

the following principles:

"1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and coinsurance.

"2. A simple system of uniform benefits provided by the federal, state, and local governments for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.

"3. A nationwide program by the private industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and coinsurance to make it economically feasible and to avoid abuse.

"4. A program developed pursuant to these principles should be administered at the state level with national standardization through federal guidelines."

now therefore be it

RESOLVED, that the Medical Society of New Jersey support all of the concepts outlined in this resolution and so notify the American Medical Association.

Rejected. The recommendation of the Reference Committee had been for adoption.

Rule on Amphetamines and Sympathomimetic Amine Drugs

From the Mercer County Medical Society

(Reference Committee "A")

Whereas, pursuant to the authority of N.J.S.A. 45:9-1 et seq., the New Jersey Board of Medical Examiners in the Division of Consumer Affairs, adopted Rule 13:35-6.16—Uses of Amphetamines and Sympathomimetic Amine Drugs; and

Whereas, this law is unduly restrictive upon the judgment of the treating physician and causes undue restraint in the exercise of good medical judgment in his customary practice of medicine; now therefore be it

~~RESOLVED, that the House of Delegates request the Medical Society of New Jersey actively to support repeal of this rule.~~

Adopted in accordance with the recommendation of the Reference Committee after editorial changes by the House in the "Resolved" to read:

RESOLVED, that the House of Delegates request the Medical Society of New Jersey actively to support repeal of Rule 13:35-6.16—Uses of amphetamines and sympathomimetic amine drugs, recently promulgated by the State Board of Medical Examiners.

Rule on Amphetamines and Sympathomimetic Amine Drugs

From John Winslow, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, the State Board of Medical Examiners of New Jersey has recently promulgated a very arbitrary set of "rules" on the prescription use of amphetamines and other sympathomimetic amines, rules that leave little room for physicians to use their own judgment in prescribing them; and

Whereas, one of the chief reasons, if not the primary one, for the growth and ascension to the top as the world force in medical care and practice by the United States has been the **FREEDOM OF THE INDIVIDUAL PRACTICING PHYSICIAN** in the country to use his own trained judgment in his care of patients and prescribing for them, rather than following arbitrary "rules" laid down from above in the previously best European traditions of professorial father-knows-best methods, a stifling form of practice which has proved so woefully wrong many times in the past; and

Whereas, the Board of Medical Examiners has grown from a small organization whose primary duties were to "register" practicing physicians and make sure their credentials were proper to a large, active, and very successful zealous enforcement arm of the Attorney General's office (see February 1979 issue of **JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY**, article by a Board member, Joseph A. Riggs, M.D.) and would appear to be ever-expanding its fields of operations in "protecting" the consumer; and

Whereas, the apparent new attitude of the Board of Medical Examiners, namely, that all physicians are in a "conspiracy" to hurt the "consumer," and the wrongdoings of all physicians must be ferreted out and those presumed guilty be brought up on charges with much publicity even before accepted proof, **WHICH ATTITUDE TOWARD THE PRACTICING PHYSICIAN IS TOTALLY CONTRARY TO A BASIC PRINCIPLE UPON WHICH THIS COUNTRY WAS FOUNDED, THAT EVERY MAN IS INNO-**

~~CENT UNTIL PROVED GUILTY; and~~

Whereas, the new rules on amphetamines are certainly NOT agreed to by many concerned and consumer-oriented practicing physicians who have no desire whatsoever to "hurt" any patients (consumers) and do not disagree out of any remote financial consideration; now therefore be it

RESOLVED, that the Medical Society of New Jersey do all in its power by persuasive legislative and legal means to have rescinded the recently promulgated regulations concerning "the uses of amphetamines and sympathomimetic amine drugs" which were published by the State Board of Medical Examiners as Rule 13:35-6.16, signed February 14, 1979, but not forwarded until after the middle of March, 1979, and becoming generally distributed and available only in April. The bases for this MSNJ action will be as follows:

- The rules represent an arbitrary, undue, and unwarranted invasion of the rights of practicing physicians to use their best medical judgment in the judicious prescribing of these drugs.
- The rules are causing undue hardship to a large number of patients while doing very little toward correcting the problem of amphetamine abuse. They may in fact be promoting illicit and dangerous channels for obtaining amphetamines.
- The rules represent what would appear to be an illegal extension of the powers of the Board of Medical Examiners beyond any directives that the Food and Drug Administration has promulgated. The rules of the FDA on the use of specific medications should have primacy, and not be subject to vigilante whims on a local or state level.
- Adoption and enforcement of these rules have caused all practicing physicians in New Jersey to be under the imminent threat of a police-state enforcement mentality which would appear totally unwarranted for the small effects against amphetamine abuse that would be accomplished;

and be it further

RESOLVED, that the Medical Society of New Jersey do all in its power through legislative and legal means to alter the whole tone and thrust of the operations of the State Board of Medical Examiners changing it from an overbearing enforcement and surveillance arm of the Department of Law and Public Safety of the State Attorney General Office to one of a helpful, advisory capacity, giving warnings to physicians deemed to be out of line, rather than building up extensive

~~"cases" against such individuals, with the resultant very negative "consumer protection" effect of taking a good physician out of practice for a relatively minor "offense" that could have been stopped by proper warning procedures when first detected.~~

Reference Committee recommendation for rejection of the resolution was not adopted. The following substitute resolution prepared by the sponsor was presented directly to the House:

Substitute #33 Rule on Amphetamines—The State Board of Medical Examiners

From John Winslow, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, the State Board of Medical Examiners of New Jersey has recently promulgated an arbitrary set of "rules" on the prescription use of amphetamines and other sympathomimetic amines, rules that leave little room for physicians to use their own judgment in prescribing them; and

Whereas, one of the chief reasons, if not the primary one, for the growth and ascension to the top of the world force in medical care and practice by the United States has been the FREEDOM OF THE INDIVIDUAL PRACTICING PHYSICIAN in the country to use his own trained judgment in his care of patients and prescribing for them, rather than following arbitrary "rules" laid down from above in the previously best European traditions of professorial father-knows-best methods, a stifling form of practice which has proved so woefully wrong many times in the past; and

Whereas, the State Board of Medical Examiners has grown from a small organization whose primary duties were to "register" practicing physicians and make sure their credentials were proper to a large, active enforcement arm of the Attorney General's Office (see February 1979 issue of JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY, pp. 109-113) and would appear to be ever-expanding its fields of operations; and

Whereas, the apparent new attitude of the State Board of Medical Examiners, namely, that all physicians are in a "conspiracy" to hurt the "consumer," and the wrongdoings of all physicians must be ferreted out and those presumed guilty be brought up on charges with much publicity even before accepted proof, WHICH ATTITUDE TOWARD THE PRACTICING PHYSICIAN IS TOTALLY CON-

TRARY TO A BASIC PRINCIPLE UPON WHICH THIS COUNTRY IS FOUNDED, THAT EVERY MAN IS INNOCENT UNTIL PROVED GUILTY; and

Whereas, the new rules on amphetamines are certainly NOT agreed to by many concerned and consumer-oriented practicing physicians; now therefore be it

RESOLVED, that the House of Delegates reaffirm its approval of Resolution #31 from the Mercer County Medical Society, which requests that the Medical Society of New Jersey actively support repeal of Rule 13:35-6.16—Uses of Amphetamines and Sympathomimetic Amine Drugs, the effect of which repeal would then leave sufficient laws in effect to deal adequately with any problems of true abuse; and be it further

RESOLVED, that the Medical Society of New Jersey do all in its power through persuasive (such as the Board of Trustees having conferences with the State Board of Medical Examiners), legislative (such as reexamining and having appropriate changes, at long last, made in the Medical Practice Act), and even legal means to investigate thoroughly the whole tone and thrust of the operations of the State Board of Medical Examiners, and if deemed necessary, changing it from an enforcement and surveillance arm of the Department of Law and Public Safety of the State Attorney General's Office to one of a helpful, advisory capacity, giving warnings to physicians deemed to be out of line, and becoming responsive to physicians seeking information and advice.

Substitute Resolution #33 adopted by the House

REFERENCE COMMITTEE "B"

Paul J. Hirsch, M.D., Somerset

Chairman

Robert S. Rigolosi, M.D., Bergen

Charles E. Dooley, M.D., Union

Donald P. Burt, M.D., Morris

Frank R. Schell, M.D., Passaic

William H. Coleman, M.D., Mercer

Alternate Member

Reports:

Board of Trustees' Item

IPA/HMO Feasibility Study

Treasurer

Committee on Finance and Budget

Committee on Medical Student Loan Fund

Committee on Publication

Resolutions #9, #10, #11

Board of Trustees' Item

STATEWIDE IPA/HMO PROJECT

(Reference Committee "B")

The New Jersey Foundation for Health Care Evaluation prepared for the Board an Executive Summary of the feasibility study of the practicality and ability to develop a single statewide IPA/HMO in New Jersey. In addition to the prepared report, copies of supporting documentation and research related to the feasibility study were available to members of the Board at the meeting.

Based on a thorough analysis of the legal and legislative issues affecting a statewide HMO, an HMO network, and a statewide IPA, it was determined that a multi-service area (MSA) HMO, capable of contracting with more than one individual practice association (IPA) in the State of New Jersey, represented the most practical approach for accomplishing the goals and objectives that were outlined in the proposal.

The Board voted to endorse and support the development of a multi-service area HMO as described in the report from the New Jersey Foundation for Health Care Evaluation, and to establish a task force with the responsibility for overseeing its implementation.

Filed in accordance with the recommendation of the Reference Committee. The task force to be formed is to report to the Board of Trustees and that report is to be considered by the House of Delegates in special session in the Fall of 1979.

IPA/HMO FEASIBILITY STUDY—SUMMARY REPORT

New Jersey Foundation for Health Care Evaluation

(Reference Committee "B")

Background—In response to growing physician interest in alternate forms of prepaid health care delivery systems (HMOs), the New Jersey Foundation for Health Care Evaluation proposed the organization of an IPA Consortium. The acronym IPA/HMO represents a fee-for-service type health maintenance organization known as an "individual practice association." Both nationally and in the State of New Jersey, the IPA/HMO appears to be gaining considerable attention as a viable alternative to the more traditional group practice, or staff model HMO promoted by the federal government.

The original proposal envisioned the establishment of a consortium, or network, of existing and developing IPAs in order to "promote and support the establishment and opera-

tion of individual practice associations through the use of shared resources and personnel." The purpose of this organization was to reduce the cost and time requirements for planning local IPA/HMOs by minimizing much of the duplicative activity involved. The proposal was submitted to the Medical Society of New Jersey for its review and support.

In May 1978, the House of Delegates voted to endorse the proposal and approved funding in the amount of \$50,000 to support its purposes. In addition, MSNJ recommended that the Foundation include as one of its objectives in this project, "to study the practicality and ability to develop a single statewide IPA/HMO. This study is to be completed and ready for reporting to MSNJ's Board of Trustees within six months of receipt of MSNJ funding."

On April 18, 1979, five and a half months after receiving funds for this purpose, a report was submitted to the Board of Trustees with the following recommendations:

1. To endorse and support the development of a multi-service-area HMO as described in this report.

Referred to Board of Trustees

2. To establish a task force composed of representatives of the Medical Society of New Jersey, the New Jersey Foundation for Health Care Evaluation, County Medical Societies, and other financial contributors to this project, with the responsibility for overseeing its implementation.

The Board voted to support the first two recommendations, amending the second recommendation to read:

2. That the Medical Society of New Jersey establish a task force with the responsibility for overseeing its implementation. (The intent of the substitute recommendation is to include a fair representation from as many sources as practical.)

Referred to Board of Trustees

3. To contribute one-third of the cost of implementing this project, approximately \$100,000. The balance required, approximately \$200,000, will be obtained from those county medical societies participating in the project, as well as through private foundations and contributions from hospital facilities and private industry, in the initial service areas involved.

A decision regarding the third recommendation has been temporarily postponed pending the completion of the work of the Task Force, scheduled for the fall of 1979.

Feasibility Study—In order to undertake this study, three

models were identified and evaluated as possible prototypes for the Statewide IPA/HMO organization:

1. **Statewide HMO**—A single health maintenance organization capable of entering into contracts with one or more individual practice associations, providing medical services in one or more separate geographic areas of the State of New Jersey.

2. **Statewide IPA**—A single individual practice association capable of contracting with a substantial number (or majority) of physicians through the State of New Jersey, for the provision of medical services in accordance with agreements negotiated with various organizations.

3. **Network**—A coordinated system of health maintenance organizations (of the IPA-type) capable of providing centralized administrative, marketing, managerial, and information services to its member organizations.

Based on a thorough analysis of the legal and legislative issues affecting each of these models, it was determined that a "Multi-Service Area" (MSA) HMO represented the most practical approach for accomplishing the goals and objectives outlined in the proposal. According to the report developed by Epstein Becker Borsody and Green^a, the MSA/HMO:

- Faced less potential exposure to antitrust liability,
- Was the only model which would be able to secure Medicare and Medicaid contracts, and
- Was assured exemption from federal income tax.

In addition to serving as the central administrative organization for each individual practice association which enters into a contract with it, the MSA/HMO could conceivably provide centralized marketing and managerial services to other operational IPA/HMOs, thus fulfilling some of the functions of a network. A schematic representation of these organizational relationships is presented in Exhibit A.

A second focus of the feasibility study involved an assessment of the market potential for the MSA/HMO. In order to develop their enrollment projections, Frank B. Hall Company supports the hypothesis that a centralized marketing effort will generate the maximum number of subscribers for all IPA/HMOs in the State of New Jersey. This theory is based primarily on the advantages to be accrued by marketing to large employer groups whose employees reside in the service areas of several HMOs. By employing multivariate analysis techniques for market forecasting, an estimated MSA/HMO enrollment of almost 200,000 persons was projected.

Finally, the report deals with the cost and financial considerations involved in the development of a MSA/HMO. Presently, a physician group which is interested in organizing an IPA/HMO in their community is faced with two choices for funding such a project:

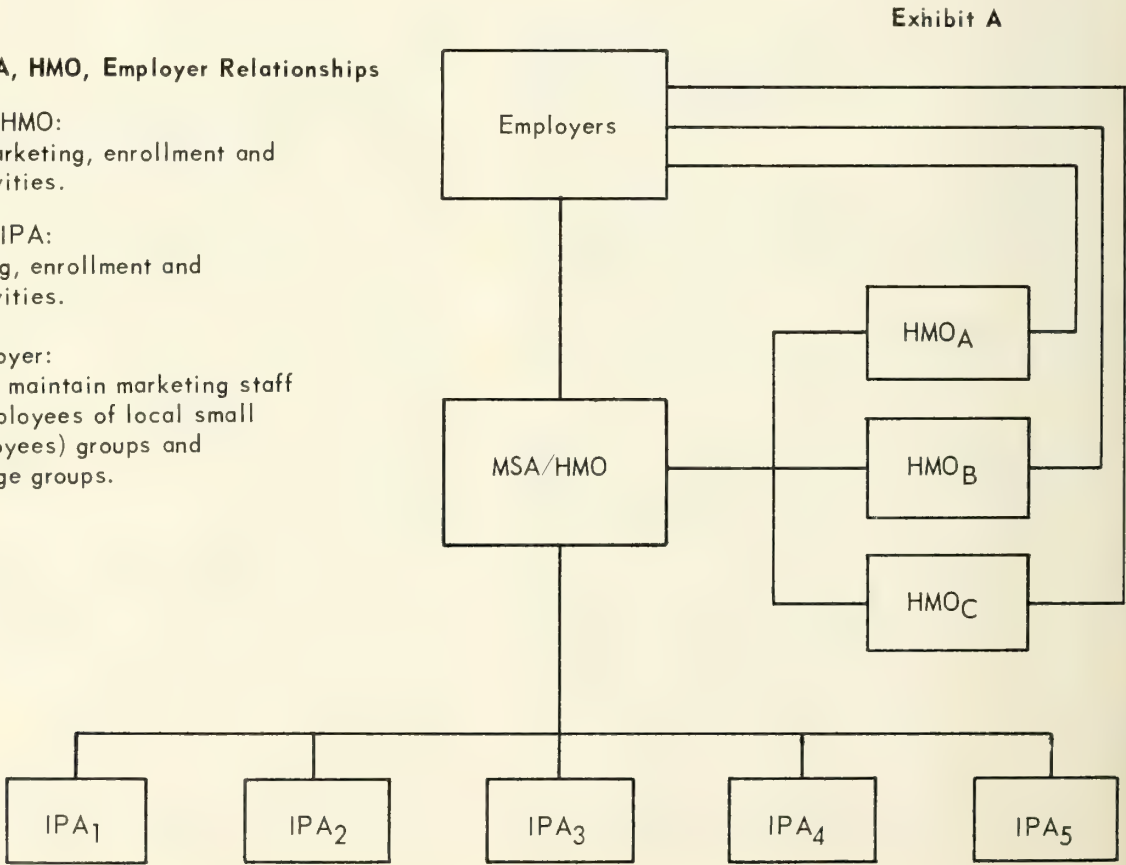
1. Seek federal planning grants, or
2. Attempt to raise the funds locally.

Currently, under the Federal HMO Act, non-profit organizations may apply for grant monies to fund the development costs of creating an HMO. These funds usually average a total of about \$700,000 over a time frame spanning at least three years. Although much of the planning involved could be accomplished more expeditiously and for less money if undertaken without federal ties and bureaucratic "red tape," the sources of private funding are limited and local efforts to secure these funds often are not realistic. Certain insurance carriers may offer partially to fund new HMO initiatives. However, many IPA supporters feel that the long-term commitments required by the carriers for such funding can

^aLaw firm located in New York City and Washington, D.C.

MSA/HMO: IPA, HMO, Employer Relationships

- MSA/HMO – HMO:
specified marketing, enrollment and related activities.
- MSA/HMO – IPA:
All marketing, enrollment and related activities.
- HMO – Employer:
Local HMOs maintain marketing staff to enroll employees of local small (0-249 employees) groups and selected large groups.



inhibit the operational flexibility the project may require at a later date.

Based on their work with several privately funded HMO projects, including medical foundations, consultants from Jurgovan and Blair, Inc.^b estimated a budget of approximately \$320,000 for the planning and development of the MSA/HMO. The incremental cost associated with each additional IPA component was estimated at \$64,000. Hence, the projected cost for establishing a MSA/HMO initially contracting with two IPAs would be approximately \$385,000, or about one-half the cost of a federally funded project for a single plan.

Perhaps as important is the timetable for accomplishing the various tasks involved in developing a privately funded HMO. Their experience has succeeded in reducing the time requirement by two-thirds, or approximately thirteen months.

By applying these time and cost savings to the MSA/HMO, the true savings to the IPA physician groups and potential HMO subscribers can be appreciated. The theory is based on the simple dictum which assumes that “we need *not* reinvent the wheel” for each IPA/HMO. There are several potential IPA/HMO groups in various stages of development, including: those within the Passaic, Bergen, Hudson, Union, Middlesex, Somerset, Salem, and Cumberland County Medical Societies, as well as physicians from the Princeton, Hunterdon, Helene Fuld, and Greater Paterson Medical Centers. (see map Exhibit B) The MSA/HMO potentially could implement and coordinate the delivery of a prepaid health care program for physicians in all of the above communities under a single umbrella organization, sponsored and supported by the Medical Society of New Jersey.

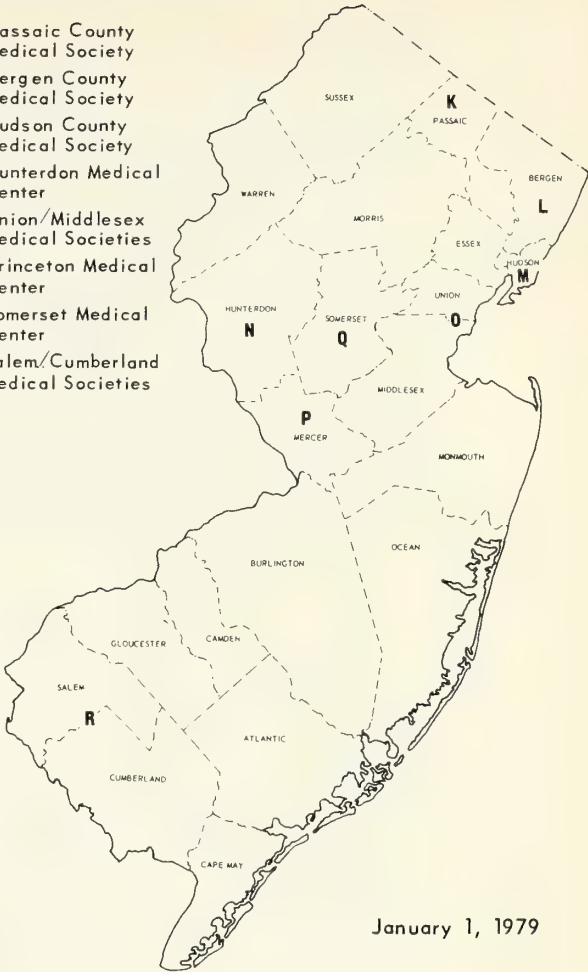
Filed after referral to Board of Trustees as noted.

The Reference Committee pointed out that the task force to be formed is to report to the Board of Trustees and that the report is to be considered by the House of Delegates at its special session in the Fall of 1979.

**OPEN PANEL IPA/HMOs
PLANNING & DEVELOPING**

Exhibit B

- K. Passaic County Medical Society
- L. Bergen County Medical Society
- M. Hudson County Medical Society
- N. Hunterdon Medical Center
- O. Union/Middlesex Medical Societies
- P. Princeton Medical Center
- Q. Somerset Medical Center
- R. Salem/Cumberland Medical Societies



January 1, 1979

^bFinancial and management firm located in Washington, D.C.

Treasurer

Rudolph C. Gering, M.D., Treasurer, Trenton

(Reference Committee “B”)

This 1979 interim report has been prepared from the books and records of the Medical Society of New Jersey by our external auditors, Ernst & Ernst.

These figures are unaudited for the reason that the fiscal year does not end until May 31, 1979.

The balance sheet and financial statements are in conformity with a new accounting system being developed for the Society which will provide a more concise and clear

picture of the Society’s financial status and at the same time implement a format recommended by the American Institute of Certified Public Accountants.

All statements are prepared in the form that will be utilized for the annual audits.

Filed in accordance with the recommendation of the Reference Committee.

Balance Sheet—January 31, 1979 (Unaudited)

Assets

Current Assets

Cash	\$ 101,016
Marketable securities—at cost (approximates market)—Note B	869,385
Accounts receivable—member assessments	998,088
Medical student loans—current portion	43,815
Advances to the New Jersey Foundation for Health Care Evaluation	41,840
Prepaid expenses and other current assets	72,271
Total Current Assets	2,126,415

Property, Plant and Equipment—Note C

Land	150,000
Building and improvements	1,369,965
Furniture and fixtures	206,548
Less allowances for depreciation	(41,792)
	1,684,721

Medical student loans—noncurrent portion, net of allowance for doubtful loans of \$70,865	234,075
Other assets	21,195
	<u>\$4,066,406</u>

Liabilities and Fund Balance

Current Liabilities

Accounts payable and accrued expenses	\$ 227,296
Assessments collected for the American Medical Association	129,250
Deferred revenue	1,254,302
Current portion of long-term debt	45,810
Total Current Liabilities	1,656,658

Long-Term Debt —less current portion—Note C	768,308
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Fund Balance	1,641,440
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Commitments —Notes D and E	
(See notes to financial statements)	<u>\$4,066,406</u>

Statement of Changes in Financial Position
Eight Months Ended January 31, 1979 (unaudited)

Funds Were Used For

Excess of expenses over revenues	\$272,093
Items which do not (use) provide funds	
Depreciation	(30,739)
Provision for doubtful medical student loans	(70,865)
Decrease in litigation reserve	23,202
	193,691

Funds Used For Operations

Additions to property, plant, and equipment	643,929
Increase in medical student loans	33,000
Repayment of long-term debt	74,387
Total Funds Used	945,007

Funds Were Provided by

Sale of property, plant, and equipment	215,389
Repayment of medical student loan	58,125
Decrease in other assets	3,601
Increase in long-term debt	32,970
Total Funds Provided	310,085

Decrease in Working Capital	<u>\$634,922</u>
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Statement of Revenues, Expenses, and Changes in Fund Balance
Eight Months Ended January 31, 1979

Revenues	
Membership assessments earned	\$ 628,497
Publication sales and advertising income	56,793
Investment income	65,929
Gain on sale of property, plant, and equipment	85,009
Other income	38,485
Total Revenues	<u>874,713</u>
Expenses	
Member services	258,992
Conferences and meetings	68,413
Publications	131,031
Grants to medical institutions	30,000
Total Program Expenses	<u>488,436</u>
General and administrative	528,539
Interest	58,966
Provision for doubtful medical student loans	70,865
Total Expenses	<u>1,146,806</u>
Excess of Expenses Over Revenues	(272,093)
Fund Balance at June 1, 1978	<u>1,913,533</u>
Fund Balance at January 31, 1979	<u>\$1,641,440</u>
See notes to financial statements	

Analysis of Changes in Working Capital

Increase (decrease) in current assets	
Cash	\$(229,171)
Marketable securities	(336,180)
Medical student loans—current portion	43,815
Member assessments receivable	919,968
Advances to the New Jersey Foundation for Health Care Evaluation	40,860
Prepaid expenses and other current assets	8,155
	<u>447,447</u>
Increase (decrease) in current liabilities	
Accounts payable and accrued expenses	166,935
Assessments collected for the American Medical Association	123,497
Deferred revenue	757,222
Current portion of long-term debt	34,715
	<u>1,082,369</u>
Decrease in Working Capital	<u>\$ 634,922</u>

See notes to financial statements

NOTES TO FINANCIAL STATEMENTS

January 31, 1979 (unaudited)

Note A—Summary of Significant Accounting Policies

Organization: The Society qualifies as a tax-exempt organization under Section 501(c) (6) of the Internal Revenue Code, and all of its income generated through the advertising included in its medical journal, is exempt from Federal and State income taxes. The tax liability, if any, would be immaterial.

Property, Plant, and Equipment: Property, plant, and equipment are recorded at cost. Depreciation is computed on the straight-line method over the estimated useful lives of the assets.

Revenue Recognition: Membership assessments and subscriptions are recognized as income during the course of the membership period which extends from January 1 to December 31. Unearned membership assessments and subscription income are recorded as deferred revenue.

Functional Allocation of Expenses: The costs of providing services to the various programs and other activities have been summarized on a functional basis in the statement of revenues, expenses, and changes in fund balance.

Note B—Marketable Securities

As of January 31, 1979, marketable securities are comprised of the following:

U.S. government obligations	\$584,385
Bank repurchase agreements	285,000
	<u>\$869,385</u>

Note C—Long-Term Debt

At January 31, 1979 long-term debt is comprised of the following:

Unsecured installment note—payable to bank, bearing interest at the prime rate, principal payments are \$393 monthly through October 1985	\$ 31,793
Mortgage loan—payable to bank, bearing interest at 3/4% above the prime rate, principal payments are \$3,425 monthly through February 1998 (collateralized by property with a book value of \$1,498,826)	782,325
	814,118
Less current portion	45,810
	<u>\$768,308</u>

Note D—Pension Plan

The Society has a noncontributory pension plan covering substantially all personnel. Total pension expense for the eight months ended January 31, 1979 was \$44,907. The Society's policy is to fund pension costs accrued. As of June 1, 1978, the most recent valuation date, the net assets of the pension fund exceed the actuarially computed value of vested benefits by approximately \$214,000.

Note E—Commitments

The Society has the following commitments:

- a. The construction of building improvements amounting to approximately \$385,000.
- b. A contribution of \$20,000 pledged to The Foundation of the College of Medicine and Dentistry of New Jersey to be paid over the next two fiscal years.
- c. A tentative agreement with The Prudential Insurance Company of North America to refinance the existing mortgage and finance additional construction costs. The Society will receive \$1,600,000 at 10% for 15.3 years under this agreement.

Finance and Budget

Richard E. Lang, M.D., Chairman, Passaic

(Reference Committee "B")

The Committee considered the overall financial status of the Society including two disturbing trends. The 1978-79 Budget was predicted upon a dues-paying membership of 8,280. Only 6,900 members paid dues for this year. It is unlikely, therefore, that the Society will make up the difference of 1,380 dues-paying members between this date and the close of the dues year on December 31, 1979.

There are a number of factors contributing to this situation. One is a definite loss of membership, although this is not as dramatic as the statistics indicate. There is a definite trend for more and more members to become either dues-exempt or to apply for and receive emeritus status. There were, at the end of March, 8,147 members listed as dues-paying. At this same time, there were 820 regular members placed in the dues-exempt category and an additional 523 members in the emeritus class. As indicated earlier, only 6,900 of the 8,147 dues-paying members have paid their 1979 dues. Delinquency is a very serious problem. These people have not resigned, died or transferred, but are not paying their dues or are having their dues withheld from the Medical Society of New Jersey by their component societies. In prior years, this discrepancy at a similar point of measurement would be about 500 to 600. Most of these people would be dropped from the roll in June and be reinstated by September. This year, however, the number is well over one thousand. This situation must be corrected.

This is the overview of the Society's position from which the Committee then proceeded.

A. Proposed Changes in Medical Society of New Jersey Bylaws

This matter was referred to the Committee by the Board. It, in effect, calls for an acceleration of dues collection. Many county societies oppose it. Your Committee favors the concept. The answer, however, lies in an in-depth study of the Medical Society of New Jersey dues system by the Committee on Finance and Budget and the Committee on Constitution and Bylaws and a total revision thereof. The Committee was unanimous in the following recommendations which also have also been approved by the Board of Trustees.

RECOMMENDATIONS:

~~(1) That the Committee on Finance and Budget and the Committee on Constitution and Bylaws be charged with the responsibility of studying and developing Bylaw amendments that will provide the Medical Society of New Jersey with a sure and stable financial base and a collection system that will produce total collection of dues within the first quarter of a given dues year.~~

Amended by the House to read:

That the Board of Trustees form a committee from among the entire State Medical Society to work on the problems of dues collection and membership in the State Society.

Approved as amended by the House.

(2) That a special session of the House of Delegates be scheduled in the Fall of 1979 to act upon the Bylaw changes that are developed by this study and approved by the Board of Trustees.

Approved in accordance with the recommendation of the Reference Committee.

B. Resolution #23—Stipend for the President and Chairman of the Board of Trustees

This matter was referred to the Committee by the Board of Trustees. Many concepts and approaches were considered. The Committee finally resolved that the President and the Chairman of the Board of Trustees each should receive an annual stipend of \$20,000. Those amounts have been projected in the budget and are incorporated in Accounts D-1 and E-1. The Board of Trustees concurs with us in this recommendation.

C. 1979-80 Budget (1980 Dues)

The Committee presented the 1979-80 proposed budget for approval of the Board and submission to the House of Delegates. The budget and assessments are projected on the basis of 7,500 dues-paying members. If the special assessment referred to below raises more than \$160,000, the excess is to

be applied to the Medical Society of New Jersey General Fund (Unappropriated) Surplus. In the event membership statistics improve by September 1979, it is recommended that the House of Delegates authorize the Board of Trustees to reduce the dues in conformity to the adopted budget and promptly so notify the component societies.

The proposed budget, as submitted by the Committee on Finance and Budget was approved by the Board.

RECOMMENDATIONS:

(1) That the Budget for 1979-80 be adopted in the total sum of \$1,500,000.

Approved in accordance with the recommendation of the Reference Committee.

(2) That the 1980 assessment be set at \$200 per regular dues-paying member.

Approved in accordance with the recommendation of the Reference Committee.

(3) That a special assessment of \$20 be levied for the New Jersey Foundation for Health Care Evaluation.

Approved in accordance with the recommendation of the Reference Committee.

(4) That the 1980 assessment be set at \$20 per capita for affiliate and associate members.

Approved in accordance with the recommendation of the Reference Committee.

(5) That the 1980 assessment for medical students remain at \$5.

Approved in accordance with the recommendation of the Reference Committee.

Budget Information—1979-80

	Proposed Budget 1979-80
A-1 & 2 Salaries & Pension Plan	\$ 580,000.00
A-3 General Office Expense	40,000.00
A-4 Executive Travel & Educational Mtgs.	8,000.00
A-5 House Maintenance, Building Expense Facilities Operation	322,000.00
A-6 Treasurer (Audit, Investment, Commissions, Tax Returns)	14,000.00
A-7 Councils & Committees (with exceptions of those listed separately)	18,000.00
A-9 Salary Taxes	36,000.00
A-10 Insurance (Liability, Financial Bond, Publication, Staff Fringe Benefits)	36,000.00
A-11 House Reserve—Office Equipment Leases and Replacement	18,000.00
A-12 ERISA Actuarial Expense	2,400.00
A-14 EDP Service-MSNJ Comp. Record Keeping	24,000.00
C-2 Legislation	10,000.00
C-4 Public Relations	125,000.00
D-1 President & Presidential Officers	33,000.00
D-2 AMA Delegates	37,000.00
D-3 MSNJ Auxiliary	11,000.00
D-4 Medical Education	28,000.00
D-6 Membership Directory Preparation	40,000.00
E-1 Board of Trustees	35,000.00
E-2 Contingent	25,640.00
E-3 Judicial Council	3,000.00
E-4 Legal	13,000.00
E-5 CMDNJ-Foundation	10,000.00
E-6 Medical Student Loan Fund	3,000.00
E-7 Reimbursement of Representatives to Mtgs.	7,960.00
E-8 Addition to Reserve	20,000.00
Total Budget	<u>\$1,500,00.00</u>

Filed in accordance with the recommendation of the Reference Committee.

Medical Student Loan Fund

Charles Cunningham, M.D., Chairman, Vineland

(Reference Committee "B")

In its twenty-two years of operation the Medical Student Loan Fund has granted loans totaling \$568,644.35 including \$444.35 as insurance payments, bringing the net loans granted to \$568,200.

To date the Fund has issued 457 loans to 283 New Jersey medical students. One hundred and ninety-four loans have been repaid in full. Twenty-two borrowers presently are making quarterly loan repayments on an annual basis, thirty-five borrowers are making quarterly interest payment until the notes become due.

Twenty-eight requests for financial assistance by New Jersey medical students were received during the 1978-79 administrative year, and twenty-one loans in the amount of \$1,500 each were granted for a total of \$31,500. It is expected that this trend will continue for some time.

It is estimated that the Fund will have \$45,775 available for loans for the 1979-80 school year to accommodate thirty students at \$1,500 each. Of this amount \$19,500 is committed to thirteen reapplicants and \$25,500 to seventeen new applicants.

This report does not reflect all the anticipated applications from other qualified medical students and your Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel it can afford to increase the \$1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest free basis. This year fifteen loans have been paid in full, a total of \$16,700. The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends Mr. Squireck and the student interviewers for their consistently efficient administrative assistance.

CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

(1) General Fund:

Medical Society of New Jersey, Board of Trustees; MSNJ's Auxiliary Executive Board; Burlington, Cape May and Passaic County Medical Societies. County Auxiliaries: Burlington, Camden, Cape May, Essex, Gloucester, Hunterdon, Mercer, Middlesex, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren, Shahrokh Ahkami, M.D., Mrs. Don A. Epler, Dr. and Mrs. Philip Fiscella, Mrs. Douglas Hammett, Mrs. Paul J. Hirsch, Dr. and Mrs. Joseph R. Jehl, Samuel Lloyd, M.D., Nicholas E. Marchione, M.D., Dr.

and Mrs. Paul H. Pettit, Dr. and Mrs. Joseph Scarno, Mr. and Mrs. Matthew Squireck, Mrs. Peter P. Walles, and Parvin Zanjani.

(2) In Memory of:

Bernard F. Alpren, M.D., Frank M. Ash, M.D., Mrs. Florence Asquine, Charles Byron Blaisdell, M.D., Robert Bozzi, M.D., Samuel T. Busansky, M.D., Mrs. James Castranova, Louis Cohen, M. Marvin Cohen, M.D., Mrs. Charles V. Craster, Leopold S. David, M.D., H.A. Dean, Salvatore J. DeCicco, M.D., Miss Ana Del Castillo, Mrs. Frances Devenney, Rosalie Dietz, Mrs. Ferdinand Engelhart, James Ferrara, Abraham M. Fiering, M.D., Mrs. Lewis C. Fritts, Martin Gewecke, M.D., Buel Gittleman, Ralph Gordon, M.D., Paul Grossbard, M.D., Neena Gupta, M.D., Mrs. D. Leo Haggerty, Earle W. Harris, John Vernon Hughes, M.D., Floyd D. Hunter, M.D., Mrs. Florence M. Kain, Elton W. Lance, M.D., Altan C. Leibovitz, M.D., Herman Levy, M.D., May Lloyd, Robert M. Lukens, M.D., Ernest C. Lydecker, M.D., Mrs. Alvin Mancusi-Ungaro, Eleanor McCrae, I. Edward Ornaf, M.D., Arthur B. Peacock, M.D., Michael L. Rachunis, M.D., Salvatore J. Rose, M.D., William B. Ruocco, M.D., Harold Rusbridge, M.D., Mrs. Lila Salasin, Emanuel M. Satulsky, M.D., Naomi Seymour, Robert L. Wallace, Jr., Mrs. Thelma L. Wenzel, John C. Whitaker, M.D., Anne Widerman, Dean A. Wry, M.D., and Mrs. M. Zeller.

(3) In honor of:

1977-78 MSNJ Auxiliary Executive Board, Robert Dorian, Mrs. David Gehring, Mrs. Douglas Hammett, Robert Hollander, Mr. Andrew Hutchinson, James Macho, Cathy Pegues, Mark Spatola and Shirley Walsh.

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 140 graduates are located as follows:

Interns—18 in New Jersey and 28 out of state	46
Residents—17 in New Jersey, 29 out of state, 1 in Canada, and 1 in England	48
Armed Services—1 Army of the United States, 2 United States Navy, and 1 United States Air Force	4
Private Practice—	
2 Arizona	4 California
2 Connecticut	2 Florida
1 Illinois	1 Indonesia
2 Massachusetts	12 New Jersey
6 New York	1 Ohio
5 Pennsylvania	1 South Carolina
3 Virginia	42
Students Presently in Medical School—2-Fifth Channel, 6 seniors, 12 juniors, and 1 sophomore	21
Current Student Loans Outstanding	161
Medical Students Paid in Full (194 loans)	122
Total New Jersey Medical Students listed earlier).....	283

DISTRIBUTION OF LOANS

County of Residence	Students Medical School	Loans Granted	
		1957-78	1978-79 March 31, 1979
Atlantic	Hahnemann	3	\$ 3,000.00
	N.J. Medical	1	1,000.00
	Pittsburgh	1	2,000.00

	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Albert Einstein	1	3,000.00	
	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Georgetown	1		\$ 1,500.00
	Hahnemann	3	5,000.00	
	Jefferson	3	7,500.00	
	Loyola-Stritch	1	3,000.00	
	Med. Coll. Pa.	1	3,000.00	
	N.J. Medical	11	17,000.00	
	N.Y. Medical	3	5,500.00	
	Rutgers	3	4,500.00	3,000.00
	St. Louis	2	3,000.00	
	Tufts	2	4,500.00	
	U. of Pa.	1	3,000.00	
Burlington	Duke	1	4,000.00	
	Georgetown	1	3,000.00	
	Hahnemann	2	4,000.00	
	Jefferson	3	9,500.00	
	Med. Coll. Pa.	1	1,500.00	
Camden	Albert Einstein	2	3,000.00	
	Hahnemann	5	9,500.00	
	Jefferson	4	8,000.00	1,500.00
	Michigan	1	2,000.00	
	N.J. Medical	2	2,700.00	
	Penna. State U.	1	1,500.00	1,500.00
	Temple	5	7,500.00	
	Tufts	1	3,000.00	
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	4,000.00	
	Bern	1	2,000.00	
	Creighton	3	7,500.00	
	Duke	1	2,000.00	
	Emory	1	3,000.00	
	Georgetown	4	5,500.00	1,500.00
	Hahnemann	4	9,500.00	
	Howard	1	300.00	
	Jefferson	1	3,000.00	1,500.00
	N.J. Medical	22	56,400.00	1,500.00
	N.Y. Medical	2	2,000.00	
	Stanford	1	3,000.00	
	St. Louis	1	500.00	
	Temple	1	1,000.00	
	Tufts	4	7,500.00	1,500.00
	Wisconsin	2	3,000.00	
	Yale	1	1,500.00	1,500.00
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00	
	Virginia U.	1	1,000.00	
Hudson	Boston	1	3,000.00	
	CMDNJ—5th Channel	1	1,500.00	
	Georgetown	1	1,000.00	
	Geo. Washington	1	3,000.00	
	Hahnemann	1	1,500.00	
	Harvard	1	1,000.00	
	Howard	1	400.00	
	Med. Coll. Pa.	2	3,000.00	
	N.J. Medical	22	37,650.00	
	N.Y. Medical	1	1,000.00	
	Pittsburgh	1	3,000.00	
	St. Louis	1	2,000.00	
Hunterdon	Hahnemann	1	3,000.00	
	Med. Coll. Pa.	1		1,500.00
	Rutgers	1	1,500.00	
Mercer	CMDNJ—5th Channel	2	3,000.00	
	Georgetown	2	4,500.00	
	Hahnemann	5	9,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	

	Louisville U.	1	4,500.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N.J. Medical	6	11,000.00	
	N.Y. Medical	1	1,500.00	
	Penna. State U.	1	1,000.00	
	Rutgers	1	1,500.00	
	St. Louis	1	700.00	
	Tufts	1	3,000.00	
	Wisconsin	1	1,500.00	
Middlesex	Boston U.	1		1,500.00
	Georgetown	3	4,500.00	
	Hahnemann	1	4,000.00	
	Loyola-Stritch	1	1,500.00	
	N.J. Medical	2	3,000.00	
	N.Y. Medical	2	4,500.00	
	Rutgers	1	3,000.00	
	Univ. of Va.	1		1,500.00
	Wisconsin	1	1,500.00	
Monmouth	Albert Einstein	1	1,500.00	
	Bowman Gray	1	1,500.00	
	Columbia	1	2,000.00	
	Duke	1	3,000.00	
	Georgetown	2	2,500.00	
	Hahnemann	2	3,000.00	1,500.00
	Jefferson	2	6,000.00	
	Loyola-Stritch	1	4,500.00	
	Marquette	2	3,500.00	
	Med. Coll. Pa.	1	1,500.00	
	N.J. Medical	3	10,000.00	
	Temple	1	2,000.00	
	Up-State N.Y.	1	1,000.00	
	N.Y. Medical	1	4,000.00	
Morris	Albany	2	3,000.00	
	Case Western	1	3,000.00	
	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	Geo. Washington	2	3,000.00	
	Loyola-Stritch	1	1,500.00	
	Med. Coll. Pa.	1		1,500.00
	Michigan	1	1,500.00	
	N.J. Medical	4	9,000.00	
	Rush	1	1,500.00	
	Tufts	1	1,500.00	
Ocean	Boston	1		1,500.00
	Georgetown	1		1,500.00
	Med. Coll. Pa.	1	3,000.00	
	Rutgers	1	3,000.00	
	SUNY-Downstate	1	1,500.00	
	Tufts	1	3,000.00	
Passaic	Jefferson	1	3,000.00	
	N.Y. Medical	2	2,500.00	
	Univ. of Va.	1		1,500.00
	Wisconsin	2	3,000.00	
Salem	Duke	1	1,500.00	
	Jefferson	1	3,000.00	
Somerset	Georgetown	1	1,000.00	
	N.Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	CMDNJ—5th Channel	1	1,500.00	
	Cornell	1	1,500.00	1,500.00
	Florida	1	1,000.00	
	Georgetown	3	6,000.00	1,500.00
	Hahnemann	3	5,500.00	
	Jefferson	3	9,000.00	
	Johns Hopkins	1	1,500.00	1,500.00
	N.J. Medical	12	20,800.00	
	N.Y.U.	2	4,500.00	
	Wisconsin	1	3,000.00	
18 Counties	43 Medical Schools	283	\$536,700.00	\$ 31,500.00
Total Loans Granted 3/31/79				\$568,200.00

RECOMMENDATIONS

1. That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of three thousand dollars in lieu of a special per capita assessment for 1979-1980 in support of the Medical Student Loan Fund.

Approved in accordance with the recommendation of the Reference Committee.

2. That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved in accordance with the recommendation of the Reference Committee.

3. That the Medical Society of New Jersey Auxiliary be requested to make the Fund its number one project next year.

Approved in accordance with the recommendation of the Reference Committee.

Filed in accordance with the recommendation of the Reference Committee.

Publication

Daniel B. Roth, M.D., Chairman, Teaneck

(Reference Committee "B")

Nine years ago, when I became a member of this Committee, the task of publishing *The Journal* was a simple one, entrusted to the capable hands of an exceptional man, Dr. Henry Davidson. A short time after I had become Chairman, Dr. Davidson died (1973) and we (Mrs. Treptow, our assistant editor, and I) suddenly were left with the job of publishing *The Journal*. The Committee interviewed several people for the position of Editor and decided to recommend Arthur Krosnick, M.D., to the Board of Trustees. This was a most happy choice and under his guidance our *Journal* has become one of the outstanding state periodicals in the nation.

We reorganized so that never again would we be left out on a limb. Three associate editors and a manuscript review board of specialists were named to assist the Editor by providing expertise in the evaluation of submitted manuscripts. This has helped to upgrade our quality.

Our advertising staff headed by Mrs. Cookson has made many improvements. Advertising, which had decreased sharply, has been on the upswing since we contracted with United Media Associates for pharmaceutical accounts. In addition to recapturing some of those lost pharmaceutical accounts, we are attracting new people and firms who appreciate the chance to reach our readers. Both the quality and the method of our printing has been modernized and refined. Despite skyrocketing costs for paper, printing, and

postage, we have managed to stay within a manageable cost area.

A little over a year ago our graphics were changed dramatically after evaluation and recommendations by Paul Fisher of the University of Missouri School of Journalism. We plan to have further evaluation this year. We do have a very attractive and readable publication.

As the official organ of the Society, charged with the responsibility of communication with the membership, we have made continuous efforts to be of service. Our readership survey of about a year ago showed that we effectively were reaching our membership. However, we always are seeking ways of improving performance and constantly look for guidance from the Board and from the members as to what they would like to see us publish. We try to monitor activities to find out whether we are getting the message across. Our long-range goal is consistently to improve and we solicit the advice and suggestions of the entire membership.

I want to extend my personal thanks to the committee members, Dr. Julio del Castillo and Dr. John Marshall, as well as to the Editor, Associate Editors, the Manuscript Review Board, and lay staff for all their help over the years. I know that *The Journal* will continue in excellent hands.

Filed in accordance with the recommendation of the Reference Committee.

#9

AMA and MSNJ Reduced Dues for New Physicians

From the Morris County Medical Society

(Reference Committee "B")

Whereas, attitudes toward the AMA and organized medicine are formed at early stages; and

Whereas, hardcore resistance against joining the AMA is significantly lower at the student/resident level than at the physician level; and

Whereas, student and resident membership in the AMA is highly correlated with intention to join the AMA as a practicing physician; and

Whereas, physicians first entering practice are highly sensitive to the "cost" rather than "value" of joining organized medicine; and

Whereas, reduced dues for physicians first entering practice will encourage an increase in membership in organized medicine; and

Whereas, reduced AMA dues categories exist in 19 states; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey adopt a reduced-dues category for new physicians first entering practice in New Jersey; and be it further~~

Above "Resolved" amended by the House to Read:

RESOLVED, that the Medical Society of New Jersey adopt a reduced-dues category for physicians first entering practice; and be it further

RESOLVED, that this reduced-dues category incorporate both MSNJ and AMA dues; and be it further

RESOLVED, that this one-year reduction in both MSNJ and AMA dues be 50 percent for a physician's first year of practice post-residency in New Jersey.

Adopted in accordance with the recommendation of the Reference Committee after amendment by the House as indicated.

#10

Establishment of a Committee to Assist Physicians in the Art of Negotiating

From George L. Triebenbacher, M.D., Delegate, Ocean County

(Reference Committee "B")

Whereas, many members of the Medical Society of New Jersey presently are working in salaried positions for health maintenance organizations (HMOs), insurance companies, the government, etc.; and

Whereas, some of these physicians already are working under conditions that seriously would impair their ability to care adequately for patients, such as being required to see 50 to 60 patients in an eight-hour day; and

Whereas, they have not in the past, nor are they at present being trained in medical schools or elsewhere, either in business techniques or in the art of negotiation; and

Whereas, there is no active body to which a physician so encumbered can turn for assistance in negotiating the conditions under which he must work; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey proceed immediately to establish a committee, sufficiently large as to be available in all areas of the State, that will be trained in the art of negotiating, to assist physicians who find themselves in such circumstances; and be it further~~

Amended by Reference Committee to read:

RESOLVED, that the Medical Society of New Jersey proceed immediately to establish a committee, sufficiently large as to

be available in all areas of the State, that will be trained in the art of negotiating, to assist physicians in such circumstances.

~~RESOLVED, that the Board of Trustees be directed to prepare such documents as would be required to form an organization of all members, salaried or non-salaried, practicing in New Jersey; and be it further~~

Deleted by Reference Committee.

~~RESOLVED that a single, one-time assessment of \$5 per member be made to finance this investigation and preparation.~~

Deleted by Reference Committee.

Adopted as amended by the Reference Committee.

#11
New Jersey Foundation for Health Care Evaluation
From the Morris County Medical Society

(Reference Committee "B")

Whereas, the New Jersey Foundation for Health Care Evaluation was created for the sole purpose of establishing the PSRO program for the federal government and that function has been completed; and

Whereas, the funding for the Foundation had been included as a budgetary line item on the 1978 annual treasurer's report of the Medical Society of New Jersey *without* the expressed approval of the House of Delegates; and

Whereas, prior to 1978 all funding of the Foundation had been voted on by the House of Delegates annually; and

Whereas, the secondary purposes of the Foundation are

merely duplications of activities and not in the best interests of the physicians in New Jersey; and

Whereas, the federal government has terminated its financial support of the Foundation; now therefore be it

RESOLVED, that all funding for the New Jersey Foundation for Health Care Evaluation by the Medical Society of New Jersey and its membership assessments be discontinued.

Reference Committee recommended rejection and further recommended that the New Jersey Foundation for Health Care Evaluation assessment be as recommended in the report of the Committee on Finance and Budget.

Resolution #11 was withdrawn by the sponsor.

REFERENCE COMMITTEE "C"

William J. D'Elia, M.D., Monmouth
Chairman

Bernard Robins, M.D., Essex

Douglas A. Hammett, M.D., Sussex

Robert G. Salasin, M.D., Cape May

Isabelo S. Torio, M.D., Middlesex

Meynardo B. Holgado, M.D., Burlington

Alternate Member

Reports:

Board of Trustees' Items

Medical Inter-Insurance Exchange
of New Jersey

Medical-Surgical Plan of New Jersey

Committee on Medical Defense and Insurance

Committee on Retirement Plan for Physicians

Resolutions #12, #13, #14

Board of Trustees' Items

PROFESSIONAL LIABILITY SUBPANELS

(Reference Committee "C")

For several years, organized medicine in New Jersey has pursued the adoption of a pre-trial mechanism in dealing with litigation involving allegations of medical malpractice. These efforts have resulted in the consent of the Supreme Court to amend *Rule 4:21—Professional Liability Claims Against Members of the Medical Profession*, to provide for mandatory panel hearings. It is now the responsibility of the medical profession to assure that a sufficient and objective pool of medical manpower is available to staff the panels.

An urgent memo was sent to the presidents of component societies (as well as a copy to the executive secretaries/directors) in August. A copy of the list of eligible physicians from the appropriate county, currently on the roster of the Court, was enclosed. Counties were requested to revise the list and supply MSNJ with a current list of 15 to 25 physicians willing to serve on the panels.

The lists have been compiled and forwarded to the Administrative Office of the Courts.

Filed in accordance with the recommendation of the Reference Committee.

Approved a recommendation of the Reference Committee that a letter of commendation be sent to the Administrative Office of the Courts.

THIRD PARTY FEE DISCRIMINATION

(Reference Committee "C")

As requested by the 1978 House of Delegates, the New Jersey Delegation introduced a resolution to the AMA House of Delegates urging the AMA to reaffirm its position regarding third-party fee discrimination as adopted at the 1977 Interim Meeting, which states "That the AMA oppose third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician."

The resolution was adopted.

Filed in accordance with the recommendation of the Reference Committee.

New Jersey State Medical Underwriters, Inc. Medical Inter-Insurance Exchange of New Jersey

Vincent A. Maressa, Secretary-Treasurer

(Reference Committee "C")

February census reports indicate that there are 5,455 insured physicians which is a significant increase over the 5,070 insureds at the same point in the previous year.

Rates for the policy year effective February 1, 1979 were 8.3 percent lower than the previous year. Classification changes based upon experience and actuarial trending were

accomplished without any increase to any given segment of specialists or an insured class of practice.

CERTIFICATE REDEMPTIONS

Two hundred thirty-seven subordinated loan certificates have been redeemed for a total of \$702,275. They fall into the

following classifications:

- (a) Moved out of State—107
- (b) Retirement from practice—85
- (c) Deceased—41
- (d) Denial of coverage—3
- (e) Withdrawal prior to issuance of coverage—1

CLAIMS STATUS (CUMULATIVE)

The total number of cases stand at 671, with 837 insureds being involved. Of the 671 cases, 472 are open and 199 have been closed. Payments to date on closed cases have totaled \$2,070,877. Payments on cases still open have been \$51,544. Outstanding reserves on open cases are \$9,546,785.

The growth and accomplishments of the Underwriter and the Medical Inter-Insurance Exchange of New Jersey are

something we can all appreciate. The efforts of Mr. Peter Sweetland and his staff, as well as the leadership of Doctor James S. Todd and Doctor Elmer L. Grimes, continue to propel this entity forward, not only in New Jersey but in nationally recognized organizations. The 1,700 plus New Jersey physicians who have volunteered to perform peer review have helped to create a most unique and successful structure.

Copies of the annual report of the Medical Inter-Insurance Exchange of New Jersey may be secured by writing or calling the office of the Underwriter in Lawrenceville, New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

Medical-Surgical Plan of New Jersey

John S. Robinson, President, Newark

(Reference Committee "C")

For Blue Shield of New Jersey, the year 1978 was marked by two major new benefit programs, a new easy-to-understand contract, new efforts to contain health care costs, and new leadership.

NEW BENEFIT PROGRAMS

It was the year in which we introduced a higher fixed-fee program, with higher income levels for eligibility for paid-in-full service benefits. This new benefit program is called the Series 14/20. Its payments are 40 percent higher than those in the Series 750 and it provides paid-in-full benefits, through participating physicians, to unmarried, single subscribers with incomes below \$14,000 and to married subscribers with husband and wife incomes below \$20,000. It also features an easy-to-understand contract or booklet.

The program sold well after it was introduced in late year, with numerous groups and individuals enrolling to "upgrade" during 1978, or on their anniversary dates early in 1979.

The Blue Shield Dental program, designed to cover basic dental needs before major problems occur, was launched early in 1978. By year-end about 65,000 persons were enrolled. The program is available to groups of 25 or more and is based on a "building block" approach wherein large groups may "build" or add to the basic coverage.

HEALTH CARE ECONOMICS FOR MEDICAL STUDENTS

Our new efforts to contain health care costs included a series of seminars on health care economics for senior medical students at the College of Medicine and Dentistry of New Jersey. The seminars stressed the physician's pivotal role in ordering costly medical care. They were a natural outgrowth of the Plan's ongoing cost-containment educational program for physicians which features a film, produced in cooperation with the American Medical Association, entitled "The Buck Starts Here."

SECOND OPINION

Nineteen hundred seventy-eight was the year in which the

words "Second Opinion" and "Medical Necessity" became commonplace. Our Second Opinion program was started in March 1977. By year end 1978 there were some 21 experience-rated groups enrolled, with about 1,000,000 persons having Second Opinion coverage. However, utilization of the program has been exceedingly low in spite of actively publicizing the benefit within the groups. About 4,000 callers requested the names of cooperating board-certified second opinion specialists. About 1,500 persons were referred to these surgeons—but only 855 patients actually went through with consultations.

Blue Shield believes it is too early to determine valid results from the program since some current unconfirmed cases may have surgery at a later date. Also, we have no figures on costs of alternative treatments. Perhaps when the program is at least three years old and results have been thoroughly analyzed, we will know whether Second Opinion should be classified as a cost-containment program. Meanwhile, we're sure the program is contributing to quality medical care.

MEDICAL NECESSITY

In New Jersey, Blue Shield agreed to go along with a national program entitled Medical Necessity in which we would make no payment for some 42 outdated or obsolete procedures unless adequate justification was provided by the physician. It was determined in a survey made by the Plan that few New Jersey doctors were using these outdated procedures in any event. In early 1979, the Medical Necessity program was expanded to include an additional 26 obsolete procedures.

The expanded program also recommended that we back the American College of Physicians in encouraging doctors to order only diagnostic procedures applicable to the individual patient's condition rather than ordering batteries of tests for patients entering the hospital for medical purposes.

UTILIZATION REVIEW

While welcoming the new, Blue Shield continued several important cost-containment programs from earlier years.

Our Utilization Review program, designed to eliminate misuse or abuse of Blue Shield benefits, has saved subscribers more than \$5,000,000 since it was started in 1968. In fact, during 1978, the department's activities were responsible for savings of \$878,000. There is no doubt that, in addition, there is a deterrent effect which cannot be measured.

Effective sources of detection in the Utilization Review program includes analysis of physician payments, hospital audits, special studies, subscriber complaints and information from other Blue Shield departments. From these sources 78 yielded refunds from physicians. During 1978 some 65 hospital audits were made. Numerous visits were made to physicians after in-depth studies of billing practices had been concluded. Such visits resulted in elimination of misunderstandings and some monetary refunds.

The department's activities also included presentations to subscriber groups, medical students and Blue Shield employees, as well as educational posters on the subject of misuse of benefits for subscriber groups.

HEALTH EDUCATION

The Plan distributed at cost more than 10,000 copies of the 269-page book "Take Care of Yourself: A Consumer's Guide to Medical Care." The book is designed to help people become more intelligent and responsible consumers of health care. We continued to make available films and booklets on understanding health care costs and on alcoholism and drug abuse.

PROFESSIONAL RELATIONS

The Professional Relations staff maintained effective two-way communications with doctors and dentists throughout the state. Their activities in 1978 included handling more than 116,000 written and telephone inquiries. About 87 percent of the inquiries were cleared on initial contact. Department members made 1,423 visits to physicians. Staff members participated in the sign-up of primary care physicians for the Blue Cross-Blue Shield Pioneer program which is to be introduced in 1979 in Union and Middlesex Counties.

The objective of Pioneer, which combines the key element of primary ambulatory medical care (office treatment) with the strengths of the present health care delivery system, is to

contain health care costs by encouraging early treatment.

Dental representatives made 362 visits to members of that profession. In addition, the professional relations department sponsored seminars, held meetings with medical assistants, and attended conferences.

SERVICE DEPARTMENT

A total of 505,680 subscriber inquiries, written and telephoned, were answered by members of the service department in 1978. Of the total more than 186,000 were made through branch offices. The telephone section cleared 91 percent of these inquiries on initial contact, while the correspondence section cleared 68 percent within 48 hours.

ANOTHER YEAR OF GROWTH

There were 3,352,694 claims received in 1978, up 84,429 from 1977. This represents almost 14,000 claims received each working day. Payments in 1978 totaled \$162,259,000, up \$7,837,000 over 1977. Almost 60 percent of these claims were for medical services, including laboratory, x-ray and physical therapy. Some 28 percent were for surgical procedures and about one percent for obstetrical services. Anesthesia claims represented about six percent of the claims and consultations, almost five percent.

Blue Shield ended 1978 with reserves of \$10,766,000, up \$6,059,000 over 1977, representing less than 14 days of claims payments and operating expenses. Our earned subscriptions totaled \$194,517,000, up \$12,893,000 over 1977.

BOARD COMPOSITION

In 1978 our board of trustees included 20 lay persons and 15 physicians, completing our sixth year with a majority of lay persons. Our membership includes consumer, labor, business and financial representatives, women, minorities, and a good spread in ages.

Effective September 1, the Blue Shield Board of Trustees elected me president of the Plan, the first lay person to hold that post in our 36-year history. Francis J. Novak was elected executive vice president.

Filed in accordance with the recommendation of the Reference Committee.

Comparative Balance Sheet • December 31, 1978

Assets	1978	1977
Investments	\$53,145,000	\$39,093,000
Accounts Receivable		
Subscriber Premiums	6,248,000	5,961,000
National Account Program	7,775,000	8,547,000
Federal Employee Program	2,635,000	2,154,000
Other	2,550,000	2,200,000
Accrued Income on Investments	923,000	522,000
	<u>\$73,276,000</u>	<u>\$58,477,000</u>
Liabilities		
Provision for Outstanding Claims	\$33,259,000	\$30,135,000
Provision for Unpaid Claims Processing Expense	2,042,000	—
Excess of Outstanding Checks Over Balance in Bank Account	4,991,000	5,038,000
Unearned Subscription Income	8,206,000	8,297,000
Accounts Payable	3,575,000	3,027,000
Reserve for Group Contract Settlement	7,182,000	4,629,000
Deposits from Organizations	3,255,000	2,644,000
	<u>\$62,510,000</u>	<u>\$53,770,000</u>
Reserves for Protection of Subscribers	\$10,766,000	\$ 4,707,000
	<u>\$73,276,000</u>	<u>\$58,477,000</u>

Comparative Statement of Operations

	1978	1977
Earned Subscriptions	\$194,517,000	\$181,624,000
Less:		
Claims Incurred	\$165,814,000	\$154,769,000
Operating Expenses	23,338,000	20,548,000
Provision for Unpaid Claims Processing Expense	2,042,000	—
	<u>191,194,000</u>	<u>175,317,000</u>
Net Underwriting Gain	\$ 3,323,000	\$ 6,307,000
Income from Investments	3,085,000	1,682,000
Operating Gain For The Year	<u>\$ 6,408,000</u>	<u>\$ 7,989,000</u>

Statement of Reserves for Protection of Subscribers

	1978	1977
Reserves at Beginning of Year	\$ 4,707,000	\$ (3,094,000)
Operating Gain For The Year	6,408,000	7,989,000
	<u>\$ 11,115,000</u>	<u>\$ 4,895,000</u>
Reserve Adjustments:		
Non-Admitted Assets	\$ (114,000)	\$ (98,000)
Unrealized Capital	18,000	(165,000)
Miscellaneous	(253,000)	75,000
	<u>(349,000)</u>	<u>(188,000)</u>
Reserves At End of Year	<u>\$ 10,766,000</u>	<u>\$ 4,707,000</u>

Table 1
All Underwritten Services and Plan Payment

Type	# Services	%	\$ Plan Payment	%	Payment/Service
Surgical	941,189	28.1	\$ 78,688,299	48.5	\$ 83.61
Medical*	1,994,445	59.5	50,251,607	30.9	25.20
Obstetrics	45,865	1.4	13,444,202	8.3	293.13
Consultation	162,589	4.8	4,532,350	2.8	27.88
Anesthesia	208,606	6.2	15,342,492	9.5	73.55
Total	<u>3,352,694</u>	<u>100.0%</u>	<u>\$162,258,950</u>	<u>100.0%</u>	<u>\$ 48.40</u>

*Includes Lab, X-ray, Physical Therapy, etc.

The incidence rate for 1978 is 486.7 cases per thousand persons enrolled.

Table 2
Community-Rated Rider Services and Payments

Type	# Services	%	\$ Plan Payment	%	Payment/Service
Surgical	129,725	15.7	\$ 2,912,164	23.9	\$22.45
Medical	4,414	.5	329,577	2.7	74.67
Diag. X-ray	277,080	33.5	5,370,006	44.2	19.38
X-ray Therapy	2,564	.3	202,708	1.7	79.06
Physical Therapy	13,364	1.6	201,494	1.7	15.08
Pathology	399,387	48.3	3,142,681	25.8	7.87
Total	<u>826,534</u>	<u>100.0%</u>	<u>\$12,158,630</u>	<u>100.0%</u>	<u>\$14.71</u>

Table 3
Distribution of Earned Subscription Income

Earned Subscription Income	\$194,517,000	100.0%
Included Claims	165,814,000	85.2
Surgical		41.3
Medical		26.3
Obstetrical		7.1
Consultation		2.4
Anesthesia		8.1
Operating Expense	25,380,000	13.0*
Underwriting Gain	3,323,000	1.8

*Includes provision for unpaid claims processing expense.

N.J. Participating and Non-Participating Physicians By County

Fixed Fee

County	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-78
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ATLANTIC	298	286	242	26	17	1	12	11			1	96.0
BERGEN	1539	817	709	57	43	8	722	687	18	12	5	53.1
BURLINGTON	402	371	288	65	16	2	31	23	7	1		92.3
CAMDEN	821	749	487	206	53	3	72	62	6	3	1	91.2
CAPE MAY	86	83	59	18	4	2	3	3				96.5
CUMBERLAND	169	162	143	11	7	1	7	6			1	95.9
ESSEX	1737	1382	1275	37	64	6	355	346	4	2	3	79.6
GLOUCESTER	201	176	114	44	14	4	25	21	4			87.6
HUDSON	890	746	691	21	31	3	144	132	2	5	5	83.8
HUNTERDON	78	67	66		1		11	11				85.9
MERCER	620	485	452	12	19	2	135	130	5			78.2
MIDDLESEX	726	518	477	18	18	5	208	194	3	5	6	71.3
MONMOUTH	704	535	490	25	20		169	159	3	4	3	76.0
MORRIS	624	490	435	30	20	5	134	129	3	1	1	78.5
OCEAN	342	208	173	23	11	1	134	126	6	1	1	60.8
PASSAIC	680	519	469	26	20	4	161	153	3	4	1	76.3
SALEM	62	60	45	12	2	1	2	2				96.8
SOMERSET	253	209	192	8	6	3	44	42	1	1		82.6
SUSSEX	96	89	79	6	4		7	7				92.7
UNION	893	639	547	53	34	5	254	247	1	4	2	71.6
WARREN	90	83	74	7		2	7	7				92.2
OUT OF STATE	348	324	261	54	9		24	22	1		1	93.1
TOTAL	11659	8998	7768	759	413	58	2661	2520	67	43	31	77.2

N.J. Participating and Non-Participating Physicians By County

Usual, Customary or Reasonable Fee

County	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-78
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ATLANTIC	298	266	227	24	15		32	26	2	2	2	89.3
BERGEN	1539	675	595	42	35	3	864	801	33	20	10	43.9
BURLINGTON	402	338	261	61	14	2	64	50	11	3		84.1
CAMDEN	821	691	446	193	49	3	130	103	19	7	1	84.2
CAPE MAY	86	68	48	15	4	1	18	14	3		1	79.1
CUMBERLAND	169	153	134	11	7	1	16	15			1	90.5
ESSEX	1737	1201	1114	29	53	5	536	507	12	13	4	69.1
GLOUCESTER	201	169	109	43	14	3	32	26	5		1	84.1
HUDSON	890	675	628	18	27	2	215	195	5	9	6	75.8
HUNTERDON	78	61	60		1		17	17				78.2
MERCER	620	444	413	10	19	2	176	169	7			71.6
MIDDLESEX	726	455	414	18	19	4	271	257	3	4	7	62.7
MONMOUTH	704	444	407	20	17		260	242	8	7	3	63.1
MORRIS	624	417	364	28	20	5	207	200	5	1	1	66.8
OCEAN	342	174	145	19	10		168	154	10	2	2	50.9
PASSAIC	680	464	421	25	17	1	216	201	4	7	4	68.2
SALEM	62	59	45	11	2	1	3	2	1			95.2
SOMERSET	253	182	167	8	5	2	71	67	1	2	1	71.9
SUSSEX	96	81	73	5	3		15	13	1	1		84.4
UNION	893	563	484	48	26	5	330	310	6	12	2	63.0
WARREN	90	80	71	7		2	10	10				88.9
OUT OF STATE	348	231	184	38	9		117	99	17		1	66.4
TOTAL	11659	7891	6810	673	366	42	3768	3478	153	90	47	67.7

N.J. Participating and Non-Participating Physicians By Specialty

Fixed Fee

Specialty	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-78
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ANES.	554	355	332	23			199	197	2			64.1
DERM. SYPH.	202	125	121	4			77	77				61.9
INT. MED.	2160	1614	1535	79			546	544	2			74.7
NEUR. SURG.	92	72	71	1			20	20				78.3
OBST. GYN.	875	705	678	27			170	169	1			80.6
OPHTH.	411	252	248	4			159	159				61.3
ORTH. SURG.	427	288	280	8			139	138	1			67.4
OTOL.	249	169	162	7			80	78	2			67.9
PATH.	175	143	138	5			32	31	1			81.7
PED.	814	701	692	9			113	113				86.1
PHYS. MED.	50	39	34	5			11	11				78.0
PLAST. SURG.	88	40	40				48	48				45.5
ANALY. LABS	89	58				58	31				31	65.2
PROCT.	38	17	10	7			21	21				44.7
PSY. & NEURO.	800	572	555	17			228	228				71.5
RADIOLOGY	417	313	287	26			104	103	1			75.1
SURG.	996	776	742	34			220	220				77.9
THOR. SURG.	90	71	70	1			19	19				78.9
UROL.	246	161	157	4			85	85				65.4
PODIATRY	456	413			413		43			43		90.6
GENERAL	2430	2114	1616	498			316	259	57			87.0
TOTAL	11659	8998	7768	759	413	58	2661	2520	67	43	31	77.2

N.J. Participating and Non-Participating Physicians By Specialty

Usual, Customary or Reasonable Fee

Specialty	Total Elig. Phys.	Participating					Non-Participating					% P.P. as of 12-31-78
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.	
ANES.	554	333	312	21			221	217	4			60.1
DERM. SYPH.	202	105	101	4			97	97				52.0
INT. MED.	2160	1483	1408	75			677	671	6			68.7
NEUR. SURG.	92	48	47	1			44	44				52.2
OBST. GYN.	875	627	602	25			248	245	3			71.7
OPHTH.	411	238	236	2			173	171	2			57.9
ORTH. SURG.	427	227	219	8			200	199	1			53.2
OTOL.	249	146	138	8			103	102	1			58.6
PATH.	175	107	105	2			68	64	4			61.1
PED.	814	616	607	9			198	198				75.7
PHYS. MED.	50	29	26	3			21	19	2			58.0
PLAST. SURG.	88	32	32				56	56				36.4
ANALY. LABS.	89	42				42	47				47	47.2
PROCT.	38	17	11	6			21	20	1			44.7
PSY. & NEURO.	800	530	513	17			270	270				66.3
RADIOLOGY	417	285	261	24			132	129	3			68.3
SURG.	996	688	655	33			308	307	1			69.1
THOR. SURG.	90	64	63	1			26	26				71.1
UROL.	246	155	151	4			91	91				63.0
PODIATRY	456	366			366		90			90		80.3
GENERAL	2430	1753	1323	430			677	552	125			72.1
TOTAL	11659	7891	6810	673	366	42	3768	3478	153	90	47	67.7

OFFICERS

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Francis J. Novak, Executive Vice-President and Secretary-Treasurer

Jean R. Geiger
Vice-President—
Communications

W. John Gould
Vice-President—Corporate
Planning and Finance

Charles L. Cuniff, M.D.
Vice President—Medical Affairs
and Medical Director

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John F. Waters (1979)

TRUSTEES EMERITUS

	<i>Appointed</i>	<i>Term as Board Member</i>
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.†	1971	1962-1971
John S. Thompson	1966	1942-1965
Thomas J. White, M.D.	1973	1951-1973
Joseph M. Keating, M.D.	1975	1953-1975

ADVISORS TO THE BOARD OF TRUSTEES

	<i>Appointed</i>	<i>Term as Board Member</i>
Irving P. Borsher, M.D.	1965	1950-1965
Andrew P. Dedick, Jr., M.D.	1973	1961-1973
Joseph P. Donnelly, M.D.**	1978	1953-1968

*Resigned

†Deceased

**President, Blue Shield, 1968-1978

Medical Defense and Insurance

Michael J. Doyle, M.D., Chairman, Neptune

(Reference Committee "C")

In 1978, the major changes affecting our plans were as follows:

1. The National Casualty Company Professional Overhead Expense Plan rates were reduced last year after approval by the New Jersey State Department of Insurance.

2. Our Major Expense program was transferred from the National Casualty Company to the Nationwide Life Insurance Company on a guaranteed issue roll-over basis as of March 1, 1978.

3. Provision has been made for a parallel portfolio of Nationwide *Mutual* Insurance Company policies to be made

available in Nationwide *Life* Insurance Company so as to separate our programs from the automobile insurance member of the Nationwide Group.

ACCIDENT AND HEALTH INSURANCE

The Society's accident and health insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who just have completed their 48th year of service to our members. This comprehensive disability income program now affords a monthly benefit up to \$4600 during total disability due to injury or sickness. The program consists of two parts:

the Basic-Extended plan and the Long-Term plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long-Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long-Term plan up to age 65 and beyond. Both the Basic-Extended plan and the Long-Term plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to \$4600 of which up to \$2000 may be in the Basic plan and up to \$3600 a month in the Long-Term plan. Up to three policies are issuable to any member for maximum flexibility. The Company will rearrange policies and existing coverage to accommodate changing needs within the three-policy limit.

BASIC-EXTENDED PLAN

The Basic Disability plan provides as much as \$2000 monthly benefit. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than first day accident and eighth day sickness. The plan also pays, at half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime and sickness benefits extended for an additional five years, for a total of seven years. There are 3923 basic policies covering our members, with some members having two basic policies. It is the practice of the administrator to combine two basic policies into one whenever members revise or increase their insurance programs so as to simplify their recordkeeping.

LONG-TERM PROFESSIONAL INCOME PROTECTION PLAN

Members may carry up to \$3600 under this plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place, such as annuities, life insurance settlement options, and Social Security. The plan also affords six months of accident partial disability benefits at half the monthly benefit rate. Benefits may begin from the first day accident, eighth day sickness, or first day hospitalization—or from the 15th, 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. Currently 2087 members participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal income-tax purposes. Members who apply for the Basic plan within their new-member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its

accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in the doctor's original policy.

MAJOR EXPENSE PLAN

The Society's Major Expense plan was transferred to the Nationwide Life Insurance Company and a new, improved program put into effect, making professional fee coverage available for the first time under this program as an option to policyholders who are not eligible for Medicare benefits. This program is especially designed to work in conjunction with any Blue Cross and/or Blue Shield contract you may carry. The combination of the new \$200 deductible Quarter Million Dollar Major Expense Plan and some basic hospital coverage can provide excellent protection for you. There are 1934 of our members who participate in this plan.

The coverage consists of two parts:

1. **Basic Coverage**—The \$15,000 basic coverage is subject to a \$200 deductible and is paid *regardless of any other insurance or service plan you may have*. Basic coverage provides 100 percent of \$40 per day toward hospital room and board in addition to any Blue Cross or Basic hospital coverage, \$32 a shift for nursing (RN or LPN in hospital; RN out of hospital), and the scheduled amounts of the optional fee coverage.

In addition, it provides 80 percent of various services and supplies when out of the hospital. It may include professional fee coverage on an optional basis as described in the folder. All professional fee payments are, as is all basic coverage, paid in addition to other payments—in particular, Blue Shield.

2. **Quarter Million Umbrella Coverage**—This coverage is designed to take over where Blue Cross leaves off and becomes operative when \$15,000 of umbrella covered expense has been incurred. Umbrella covered expense consists of 100 percent of full semi-private hospital care including miscellaneous hospital expense, full nursing charges, and 80 percent of certain services and supplies out of the hospital. Payments are made under the Quarter Million Dollar Umbrella coverage to the extent that they have not been paid by other policies, including this one. But the Basic \$40 daily hospital benefit *and* the full semi-private benefit under the Umbrella can be payable simultaneously. This makes certain that payment will be made in the event the insured is confined to a private room in the hospital.

Thus, participants are assured of virtually complete hospital and nurse coverage even after Blue Cross Benefits have ended.

Unmarried, dependent children are covered to age 25. All members who are under age 70 and their spouses under age 70 are eligible to apply. At eligibility for Medicare, coverage for such person automatically becomes modified Basic Coverage with a \$15,000 maximum for each Covered Person, with a deductible of \$750 or the amount of Covered Expense payable by Medicare, whichever is greater. Medicare Covered Expense includes Hospital Miscellaneous Services. There is no Quarter Million Coverage or Optional Professional Fee Coverage for those eligible for Medicare. Full coverage continues for Covered Persons not eligible for Medicare. The program is administered by E. & W. Blanks-teen.

HOSPITAL-MONEY PLAN

Our Hospital-Money policy, administered by E. & W.

Blanksteen Agency, Inc., provides \$20, \$30, \$40, \$50 or \$60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse, and dependent children. New members are able to obtain the \$20-a-day program non-selectively as part of their new-member privilege. Benefits under this plan are paid regardless of other insurance and are used to supplement the benefits provided by Blue Cross, Major Expense, and Major Medical plans. It is particularly useful to provide money for private-room coverage where adequate provision is not made by underlying plans. There are 257 members participating in this program.

OVERHEAD EXPENSE PROGRAM

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals, and other fixed expenses pertaining to their practice. Our Professional Overhead Expense Program, whose rates were reduced last year, is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It now provides up to \$5,000 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. Currently, 425 members are covered under the plan. In accordance with IRS regulations, the premiums under this program are considered business expense and are tax deductible.

LIFE INSURANCE—NATIONWIDE LIFE INSURANCE COMPANY AND BANKERS LIFE COMPANY OF DES MOINES, IOWA

The maximum coverage under our Life Plan is \$250,000 with the \$100,000 maximum coverage Bankers Life Plan available in addition to the \$150,000 program of the Nationwide Life Insurance Company that has been in effect for many years. Our original Nationwide Life Insurance program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21; up to age 26 if a college student), as well as employees. An important feature of this expansion is that each person will have his own Five-Year Renewable and Convertible Term policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members, especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The Nationwide life program provides each insured person with a Five-Year Renewable and Convertible Term policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to \$150,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of \$10,000 with Waiver of Premium and Double Indemnity for accidental death included without premium charge. Since inception of the program, there have been 387 death claims, resulting in a total payout of \$4,188,000.

As a result of the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable, term life insurance at a very low cost. At the present time, over 1,800 of our members participate in the program with approximately \$31,000,000 of insurance currently in force. This plan is also available to spouses,

children, and employees and 122 of them participate in this program.

The additional \$100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of another physical examination and give our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above. So far 209 of our members have applied for and were issued \$8,225,000 of insurance protection under this new plan.

SIX-POINT, HIGH-LIMIT ACCIDENT INSURANCE PLAN

Our Six-Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Coverage is issued under this program to members under the age of 70 in the active practice of medicine, without regard to medical history. We have a special Six-Point, High-Limit Accident Insurance program enrollment at the beginning of each year. Special spouse coverage is available under this policy at very low cost. Of our members, 666 participate in this program.

PROFESSIONAL CORPORATIONS

The Basic-Extended, Long-Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six-Point High-Limit Accident Insurance Plan, Overhead Expense Plan, and Life Insurance Plan are adaptable for use in professional corporations and the necessary assignment forms are available upon request from the administrator of the plan.

RECOMMENDATION

That the E. & W. Blanksteen Agency, Inc., be continued as the Official Broker for MSNJ's Accident and Health Insurance, Major Expense Insurance, Hospital-Money Plan, Life Insurance, Six-Point High-Limit Accident Insurance, and Professional Overhead Expense Plan.

Approved in accordance with the recommendation of the Reference Committee.

PROFESSIONAL LIABILITY

Your Committee is pleased to report that the Medical Inter-Insurance Exchange of New Jersey program as administered by the New Jersey State Medical Underwriters has made our task much more pleasant than in previous years. Our role has changed somewhat to that of a monitoring organization. Unfortunately, those physicians insured through the State Reinsurance Association are still in a tentative position with their future in the hands of persons who are not necessarily dedicated to the preservation of the medical profession.

The peer review and claims management system of New Jersey State Medical Underwriters is functioning well, holds great promise, and is recognized nationally as being unique and innovative.

The Department of Liability Control is functioning well under the direction of Dr. James E. George and has established the appropriate interface with New Jersey State Medical Underwriters.

Resolution #4 which was adopted as amended by the House was discussed by the Committee and the New Jersey State Medical Underwriters.

New Jersey State Medical Underwriters was successful in working out an agreement with the Hospital Insurance Exchange of New Jersey to provide coverage to physicians serving on administrative committees in hospitals. Since the Hospital Insurance Exchange provides coverage for about 80 percent of the general hospitals in New Jersey most situations are more than adequately covered. Discussions do continue with the remaining commercial carriers, but it appears that the quickest route of resolution would be for the medical staffs in those hospitals to prevail upon their board of trustees to provide such coverage.

Detailed data on the overall condition of the New Jersey State Medical Underwriters program are available to you in the report of Mr. Vincent A. Maressa.

STATEWIDE BLUE CROSS/BLUE SHIELD PROGRAM

Nineteen hundred seventy-eight was a year of good results under the statewide Blue Cross/Blue Shield Program. Favorable claims experience produced a surplus of \$80,000—the amount distributed in 1978 to doctors who were participating in the Program on November 30, 1977, the end of the plan year in which the surplus was developed.

Premium rates, effective July 1, 1978, average 6.7 percent less than the previous rates for subscribers under age 65. Premium rates for those age 65 and over are based on community rates and were slightly increased on that date.

Enrollment figures affirm the Program's responsiveness to the needs of members. Close to 5400 doctors and employees from 18 counties are currently participating. The most recent endorsement of the Statewide Program came from the Monmouth County Medical Society. Their endorsement, effective September 1, 1978, added more than 200 doctors and employees to prior enrollment figures.

The Program continues to provide 120-day comprehensive Blue Cross coverage and a choice of the 500 Series, 750 Series, or Prevailing Fee (UCR) Blue Shield schedules.

Also provided are these additional benefits:

(1) 120 days semi-private care *per admission*, rather than per benefit year;

(2) 120 days coverage for mental conditions, tuberculosis, alcoholism, polio, and contagious diseases, rather than the standard 20 days;

(3) payment of *full semi-private rate* in non-member hospitals outside New Jersey, rather than the standard \$30 per day payment;

(4) coverage for unmarried, dependent children until the end of the year in which they reach *age 23*, rather than age 19;

(5) permitted continuation of coverage under the Program by the surviving spouse and dependent children of a deceased participating member.

Coverage is available to members of the Society regardless of their previous medical history. There are also no pre-existing condition exclusions. New members may join within two months of becoming a member and present members may join during either the June or December open enrollment period. Coverage will become effective on the

following July 1 or January 1, respectively. Coverage is also available to a doctor's full-time employees if he or she wishes to provide it as a fringe benefit program.

The Program, administered by Donald F. Smith & Associates, continues to be the most comprehensive method of providing basic health care insurance for our members.

BLUE CROSS/BLUE SHIELD GROUP MAJOR MEDICAL PROGRAM

Participation in the Major Medical Program increased by more than 200 doctors and employees during 1978. Custom-tailored to fit doctors' needs, the Program is, to the best of our knowledge, the only one of its kind and has received a high level of response from members since its inception January 1, 1977. The total number of participants already exceeds 2300.

The claims level generated by participants during the year is evidence of the increasing need for health care insurance that provides additional protection—protection above and beyond basic coverage. To ensure adequate funding for the high level of Program usage, rates were adjusted July 1, 1978 to cover projected claims.

Designed and administered by Donald F. Smith & Associates, the Program is extremely comprehensive yet competitively priced. Benefits become payable when expenses for covered illnesses and accidents exceed the benefits available under the Statewide Program of Basic Blue Cross/Blue Shield plus a calendar year cash deductible of \$100. Other highlights of the Group Major Medical Program are as follows:

- Benefits are payable on expenses incurred in or out of the hospital.

- There are unlimited lifetime benefits. (The maximum benefit per person per calendar year is \$50,000 except for out-of-hospital treatment of mental conditions, which is limited to \$1,000 per person per calendar year.)

- Physicians' and surgeons' charges are covered expenses.

- Premium rates do not increase with age.

- The full semi-private hospital room and board rate is a covered expense. If a private room is medically necessary, there is an additional allowance.

- Unmarried dependent children are covered until the end of the year in which they reach age 23.

As with the Statewide Program, new Medical Society members may join within two months of becoming a member if they have basic Blue Cross/Blue Shield coverage on a group basis. Present members may join during either the June or December open enrollment period. Coverage will become effective on the following July 1 or January 1, respectively. Coverage may be provided for full-time employees as a fringe benefit program.

RECOMMENDATION

That Donald F. Smith and Associates be continued as MSNJ's Official Broker for its Blue Cross-Blue Shield Program and its Blue Cross-Blue Shield Group Major Medical Program.

Approved in accordance with the recommendation of the Reference Committee.

Report filed in accordance with the recommendation of the Reference Committee.

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

Both of the following plans administered by E. & W. Blanksteen Agency, Inc. and PRO Services, Inc. have been reviewed by the Committee and have been approved for sponsorship again this year.

HR-10 (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

Our Keogh Plan provides tax-deductible contributions up to the lesser of \$7500 or 15 percent of earned income. In addition, voluntary contributions of up to the lesser of \$2500 or 10 percent of earned income may be made, to take advantage of the tax-free compounding and favorable final funding guarantees.

This plan was established in 1970, is administered by E. & W. Blanksteen Agency, Inc. and underwritten by The Prudential Insurance Company of America.

The program includes five unique advantages, in addition to the well-known tax-saving and tax-shelter features of the Keogh Law:

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)
2. A lifetime monthly fixed-dollar annuity.
3. Contributions even beyond age 70-1/2, as long as you are self-employed.
4. A death benefit guarantee, so that, if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.
5. Flexibility during accumulation years, permitting the allocation and transfer of funds, at the participant's option, to and from the common-stock and the fixed-dollar account.

The plan not only provides an excellent means of accumulating funds, but has a splendid final funding mechanism consisting of a Group Variable or a Group Fixed-Dollar Annuity, combined with tax-free government bond distributions. Many members who accumulate their funds elsewhere find it beneficial to transfer to this program at age 70-1/2 and take advantage of the final funding arrangement.

Throughout the state, we have 462 plans in effect, covering 549 people (since a partnership has one plan for all its partners, a retirement plan covering a partnership may have more than one physician-participant) with total deposits of \$6,868,323.40 since the plan's inception.

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended, and the Society approved in 1970, the establishment of the Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan, using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan, permits corporations, one of whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program, using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity.

This plan is administered by E. & W. Blanksteen Agency, Inc., who will be pleased to furnish members with full information concerning the plan, which should provide a

substantial savings, since it is not necessary to have a plan and trust specially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan, including that of our administrator.

PRO SERVICES, INC.

Benefits—Among the outstanding benefits available to members are the group retirement plans offered by our designated agent, PRO Services, Inc., and made available through the Medical Society of New Jersey. The plans offered are all IRS approved master prototypes and include all of the following:

IRA—These include both the regular IRA with contributions of up to \$1,750 per year and the new "Simplified Employee Pension Plan" which permits contributions of up to \$7,500 annually.

Keogh—Two plans are available: Defined Contribution and Defined Benefit.

Corporate Pension and Profit Sharing—Master Prototypes are available to fit any individual need. These include money purchase, as well as various defined benefit arrangements.

Investment Performance—While members are free to select from a wide range of marketable investment alternatives, many members have chosen to use either PRO Fund, Inc., a common stock mutual fund, or PRO Income Fund, Inc., a high quality income mutual fund.

According to "Lipper Analytical Service, Inc.," a widely recognized independent mutual fund reporting service, PRO Fund, Inc. provided investors with an increase in value per share of 15.28 percent for the calendar year 1978 (includes reinvestment of dividends). "Lipper" also rated PRO Income Fund, Inc. as the number one high-quality income mutual fund in the country during 1978, a fact that was reported in the January 22, 1979 issue of *Newsweek* magazine.

Guaranteed Issue Life Insurance—The Society always permitted life insurance as part of any of the Keogh or corporate plans offered for those individuals who wish to use this feature. In light of recent inflation and the important tax benefits now available from including life insurance in retirement plans, the amount of coverage available without proof of health has been substantially liberalized.

Additional Information—The numerous advantages, as well as a description of plan options and fees, are listed below:

ADVANTAGES

No Advisory Responsibility—The PRO Plans offer a broad range of investment possibilities—stocks, bonds, mutual funds, savings accounts, insurance, annuities and other liquid investments. The broad range of investment options best serve individual needs and free the employer of advisory responsibilities.

No Investment Liability—Each participant selects investments to meet individual needs. The employer thus avoids fiduciary responsibility as well as liability as an investment advisor.

No Record-Keeping Accountability—There is no need to assume liability as trustee of your plan. PRO Plans feature corporate bank trustee facilities to maintain account records and furnish individual reports to each Plan participant.

Continuing Advice and Guidance—Participants and employees receive PRO Services' professional advice on coordinating retire-

ment programs with lifetime financial objectives, keeping programs current and deriving fullest possible benefit from every dollar put aside. Service is rendered from inception to fulfillment of each program.

Regular Services for Plan Participants—All plan employers are eligible for and may request any of the following services:

- A. Annual "Check-Up" Service
- B. Assist Terminating Employees
- C. Enroll New Employees
- D. Contribution Reminder Notices

Full Compliance Service—On an optional basis, PRO Administrators, Inc. will act as your legal plan administrator. If this optional service is elected, PRO will assume the fiduciary responsibility for administering your plan, and will be legally responsible for preparing and filing all required government reports during each plan year as they become due.

Flexible Retirement Payout—All legal retirement options are available under the plans. For example, a participant may elect a lump sum or partial distribution, select a monthly check, or purchase an annuity with monthly income for life.

Guaranteed Life Insurance Coverage—Life insurance is available in the PRO Plan without evidence of good health.

DESCRIPTION OF THE PLAN OPTIONS AND FEES

The PRO Retirement Plans offer wide flexibility in the selection of investment options. There are two investment programs available under the plans.

Plan A

1) Investment Options Available

- A) PRO Fund, Inc. (i)
- B) PRO Income Fund, Inc. (ii)
- C) Annuity Savings Contracts
- D) Life Insurance
- E) U.S. Retirement Bonds

2) Fee Schedule for Plan A

A) Annual maintenance and processing fee	
per participant	\$27.00
B) Partial or lump sum cash distribution	1.00
C) Return of excess contribution	1.00
(i) Invests primarily in common stocks.	

(ii) Seeks highest investment income consistent with preservation of principal.

Plan B

1) Investment Options Available

- A) Individually selected common stocks, preferreds, or corporate bonds.
- B) Shares of any investment company registered pursuant to the Investment Company Act of 1940 (mutual funds).
- C) Money Market Funds.
- D) Obligations of or guaranteed by the United States.
- E) Certificates of Deposit. (Only in U.S. banks or savings and loan associations.)
- F) Savings Accounts. (Only in U.S. banks or savings and loan associations.)
- G) Life Insurance and/or Annuity Savings Contracts.

2) Fee Schedule for Plan B

- A) Asset Fee (Includes purchases under a standing investment designation—Each asset, excluding cash) \$2.00 monthly
- B) New Account or Full Termination (one-time charge) \$25.00
- C) Special Fees:
 - a) Transactions not covered by a standing investment designation (asset contribution, purchase, sale, partial liquidation, participant loan) \$15.00
 - b) Broker-directed transactions fees (regardless of number of transactions) \$10.00 monthly

Under both Plan A and Plan B, each participant may elect one or more of the options and change his investment selection as his needs or the investment climate changes. Many participants select a combination of options.

A PRO structured and administered retirement income plan maximizes benefits and cuts taxes now and in the future. It also relieves the employer of paperwork, legally required filings, and management liabilities.

More information regarding these outstanding retirement plans is available by writing or calling the Society's officially designated service agent.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#12
Blue Shield Regulations

From the Camden County Medical Society

(Reference Committee "C")

Whereas, certain physicians have agreed to become participating physicians in Blue Shield of New Jersey; and

Whereas, the purpose of this participation is to limit the medical expenses of persons of limited income; and

Whereas, significant numbers of these patients of limited income who are eligible for "service benefits" are now holders of major medical insurance policies; and

Whereas, the current Blue Shield of New Jersey precludes the physicians collecting any monies beyond the "service benefits," despite the existence of major medical insurance coverage; now therefore be it

RESOLVED, that the Board of Trustees effect a change in Blue Shield regulations that would allow participating physicians to receive fees from major medical contracts and be it further

RESOLVED, that the Board of Trustees pursue this matter to completion with the New Jersey Commissioner of Insurance should it be necessary to do so in order to accomplish the intent of the resolution.

Adopted by the House.

Reference Committee recommendation had been for referral to the Council on Medical Services for study and appropriate action.

#13

Medical Liability Insurance Premium Schedules

From the Ocean County Medical Society

(Reference Committee "C")

Whereas, the risk of medical malpractice action to any particular category of physicians is variable and dynamic, requiring frequent study and updating of loss experience data; and

Whereas, there is a general agreement that medical liability insurance premiums should reflect the actual cost and risk of providing insurance to any particular category or group; now therefore be it

RESOLVED, that the Medical Society of New Jersey supports the concept, insofar as possible, that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.

Rejected in accordance with the recommendation of the Reference Committee.

#14

Severing Relations with Blue Shield of New Jersey

From the Middlesex County Medical Society

(Reference Committee "C")

Whereas, charging patients different fees for the same service is basically unfair; and

Whereas, Blue Shield of New Jersey poses a two-fee system of participating physicians; now therefore be it

RESOLVED, that the Medical Society of New Jersey en-

courage its members to sever any former relationships with Blue Shield of New Jersey in the interest of dealing equally and fairly with each individual patient.

Referred, in accordance with the recommendation of the Reference Committee, to the Council on Medical Services for study, with report to be made to the Board of Trustees and to the House of Delegates in special session in the Fall of 1979.

Robert H. Stackpole, M.D., Union
Chairman

George L. Triebenbacher, M.D., Ocean

Michael R. Ramundo, M.D., Passaic

Carl A. Restivo, M.D., Hudson

John J. Pastore, M.D., Cumberland

John Winslow, M.D., Essex

Alternate

Reports:

Board of Trustees' Items

Committee on Medical Education

Committee on Emergency Medical
Care

Committee on Medicine and
Religion

Resolution #15

Board of Trustees' Items

BASIC MEDICAL SCIENCE STRUCTURE IN SOUTHERN NEW JERSEY

(Reference Committee "D")

A position paper adopted by the Camden County Medical Society supporting the position that a basic science facility should not be constructed in Southern New Jersey was considered at the July, 1978 meeting of the Board. At that time, the Board referred the matter to the Council on Medical Services and directed the Council, in conjunction with the Committee on Medical Education, to develop a position paper for presentation at the September, 1978 meeting of the Board. At the September meeting, the Board agreed that:

1. There is a need for an increase in the basic science capability for 100 students in New Jersey to reach the number of 400 new physicians graduated each year.

2. Existing basic medical science facilities in Piscataway and Newark should be expanded.

The Board also approved, as amended, the conclusion reached through the joint efforts of the Council on Medical Services and the Committee on Medical Education . . . "that for the present, there should be no establishment of a basic science facility in Southern New Jersey. In due course of time, if it is necessary to establish such a facility, such a facility should teach both osteopathic and allopathic students. At the present time, the concept of a 'school without walls' should be continued and the available facilities should be utilized to their fullest." This position coincided with the position taken by the Camden County Medical Society.

The Board of Trustees again voted in January to reaffirm its action of September, 1978.

Filed in accordance with the recommendation of the Reference Committee.

DEAN OF RUTGERS MEDICAL SCHOOL

(Reference Committee "D")

At the November meeting, the Board voted unanimously to submit the name of Palma E. Formica, M.D., as the Society's recommendation for appointment to the search committee to seek qualified candidates for the position of Dean of Rutgers Medical School, CMDNJ.

Filed in accordance with the recommendation of the Reference Committee.

DEPARTMENT OF FAMILY PRACTICE

(Reference Committee "D")

The 1978 House of Delegates called upon the Medical Society to petition the Board of Trustees of the College of Medicine and Dentistry of New Jersey to establish a Department of Family Practice at the New Jersey Medical School and to establish a curriculum which would provide adequate teaching of medical students by family practitioners during the second, third, and fourth years of medical school. The resolution was referred to the Dean of the New Jersey Medical School in Newark with the request that it be called to the attention of the Academic Policy Committee. To date, no reply has been received.

Filed in accordance with the recommendation of the Reference Committee.

EMERGENCY MEDICAL SERVICES REGIONALIZATION REGULATIONS

(Reference Committee "D")

The Board of Trustees supported the request of the Special Committee on Emergency Medical Care for a postponement of implementation of the proposed Emergency Medical Services Regionalization Regulation for the Designation of Emergency Medical Services Regions and Hospitals which is currently before the Health Care Administration Board.

The Committee on Emergency Medical Care believes that the draft of the regulation submitted for publication in the *New Jersey Register* was premature, since the regulation lacks information concerning possible increased costs, a defined protocol, as well as a geographic breakdown of the EMS districts, and presently is voluntary on the part of the hospital to apply for the appointment of a resource, receiving, or associate hospital.

The Committee does not disagree with the document but believes more information and interchange is needed before the regulation becomes effective.

Filed in accordance with the recommendation of the Reference Committee.

PHYSICIAN'S RECOGNITION AWARD REQUIREMENTS

(Reference Committee "D")

The AMA Council on Medical Education has adopted a

policy that certification or recertification by a recognized specialty board received within a given three-year period will not satisfy Physician's Recognition Award requirements. This policy works an undue hardship on practicing physicians and forces them to choose between specialty board requirements and fulfilling voluntary or, in some states, mandatory CME requirements.

New Jersey introduced a resolution at the AMA Interim Meeting requesting the House of Delegates to instruct the

Council on Medical Education to recognize specialty board certification or recertification received within a given three-year period as the equivalent of meeting Physician's Recognition Award requirements.

The resolution was referred to the AMA Board of Trustees for report to the House of Delegates at the 1979 Annual Meeting.

Filed in accordance with the recommendation of the Reference Committee.

Medical Education

Arthur Bernstein, M.D., Chairman, East Orange

(Reference Committee "D")

The Committee on Medical Education has been plagued all year with the problem of physicians who have not met their 150 hours of credit as first ordered by the House of Delegates in 1972. Continuous effort by the county medical societies as well as the Committee on Medical Education finally reduced the number from 582 in June of 1978 to 232 as of January 1, 1979. In accordance with the resolution adopted by the House of Delegates in 1978, it was recommended to the Board of Trustees that these 232 physicians be dropped from membership in the Society.

The Committee on Medical Education now has accredited 71 hospitals in the State of New Jersey. These hospitals are engaged actively in programs that are considered to be meeting the standards set by the AMA and the Liaison Committee on Continuing Medical Education. Twenty-four resurveys were done in 1978 as well as one new survey. There are 13 resurveys due in 1979 and one new survey waiting to be accomplished. We hope that by the time of the annual meeting most of these will have been accomplished.

Dr. Arthur Krosnick, the Editor of *The Journal* of the Medical Society of New Jersey, suggested "An Institute of Continuing Medical Education," in an editorial in *The Journal* of the Medical Society of New Jersey (August 1978, pp. 589-599). He was, therefore, asked to appear before the Committee to discuss this idea. He suggested that this Institute be a consortium between the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the

College of Medicine and Dentistry of New Jersey, the State Board of Medical Examiners, and the New Jersey Department of Higher Education, as well as the New Jersey Department of Health. The Committee had a long discussion with Dr. Krosnick on this matter and still has the question under advisement. After further study the feasibility of such an Institute will be discussed at greater length by the Committee and ultimately a report will be engendered for the Board of Trustees and then for the House of Delegates. This is a rather controversial area and must be studied carefully before a final decision is made.

In our report of last year, we pointed out that many of the state medical societies including our own felt that the Liaison Committee on Continuing Medical Education really has not represented the grass-roots physicians. There is still much discussion in this area and pressure is being put upon the Liaison Committee in an attempt to have such representation. So far there has been much talk but no accomplishment.

The members of the Committee on Medical Education deserve the thanks of the Society for their continuing efforts, as do the staff, the survey physicians, and all the county medical societies who have cooperated so well in trying to make our program a success.

Filed in accordance with the recommendation of the Reference Committee.

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Elizabeth

(Reference Committee "D")

Nineteen hundred seventy-nine will be of great significance to providers of emergency medical services and will demand a constant alertness to potential bureaucratic changes and

regulations that may affect their services, whether on a voluntary or involuntary basis. No medical or allied medical provider is against improvement in emergency health ser-

vices, but a physician would be remiss if he stood by and permitted others in government who, for the sake of power or the Federal dollar, will attempt to subvert a knowledgeable constituency of many years standing. To be alert is to be armed.

FEDERAL LEGISLATION

S-2410—Health Planning and Resources Development—

The Committee supported the proposed Hudleston-Hatch amendment #3098 that would exclude physicians' offices from the certificate of need process.

MICU LEGISLATION

The Committee recommended and supported the Council on Legislation suggestion that the term "paramedics" be changed to "emergency medical technician" to avoid a great deal of confusion and that the language in the existing statute be used. It is important to distinguish between EMT's who have taken the basic course of 81 hours of training and those who have had advanced emergency medical training of 530 hours, of which 140 are didactic training, 350 are clinical training, and 40 are on-the-job training.

Since the law regarding the five-year pilot program of Mobile Intensive Care Units reached its end on October 16, 1978 in New Jersey, the Committee recommended that the program be extended past this date until new MICU legislation is passed. (Legislation was passed extending the pilot program for another year.)

CPR TRAINING RESOLUTION

MSNJ received a communication from the State Department of Education requesting an opinion for cardiopulmonary resuscitation training in high schools. The Committee recommended and supported a resolution to have CPR training in the New Jersey high schools' curriculum on a voluntary basis (in the health classes). It also recommended that guidelines as described by the American Medical Association, American Red Cross, and American Heart Association be utilized in this training process.

The State Board of Education adopted a resolution urging all New Jersey high schools to include CPR training in their physical education, health and safety classes, as soon as may be practicable.

EMERGENCY MEDICAL IDENTIFICATION

For the second time since 1972 the Committee conducted the most successful program of its kind in the nation. Approximately 175,000 EMI cards and 3,600 posters were distributed to medical and non-medical groups and organizations throughout New Jersey.

CATEGORIZATION OF HOSPITALS

The Committee and the Inter-Agency Commission on Emergency Medical Care were represented at an invitational conference on the Categorization of Hospital Emergency Capabilities held in Chicago and sponsored by the American Medical Association. In view of the rapid changes taking place in EMS, categorization guidelines that were oriented toward trauma will be oriented more toward all emergencies in the future.

EMS PUBLIC EDUCATION AND INFORMATION

It is most important that there be effective methods of informing and educating the public in Emergency Medical

Services and teaching them how to assess their EMS systems.

EMERGENCY MEDICAL SERVICE REGIONALIZATION REGULATION

The Committee, at the request of the Board of Trustees reviewed and commented on the EMS Regionalization Regulation for the Designation of EMS Regions and Hospitals. A notice appeared in the *New Jersey Register* in December 1978. The proposed rules raised many questions by knowledgeable organizations providing these services concerning implementation of these rules and regulations with little or no satisfactory information. Although the original rules and regulations have been amended, that information as yet has not been made public. However, it appears that the primary purpose of these proposed regulations was to incorporate them in a grant application being submitted by the State Department of Health to obtain federal funds. The Committee felt that the draft regulations were premature, lacked information concerning possible increased costs, a defined protocol, as well as a geographic breakdown of EMS districts. Since rescue squads are a vital part of this system, failure of hospitals or rescue squads to participate would result in a "non-system system." If the proposed regulations take on the force of law, hospital rates of necessity would be increased for the designated hospitals and subsequently passed on to the consumer. In addition, satisfactory information is not available as to the future cost of the system. When the federal dollar ceases to be supplied to the state, the system will fail. If hospitals and rescue squads do not participate, we then envision hospitals will be commanded to participate.

INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE—EMERGENCY DEPARTMENT NURSES TRAINING PROGRAM

The ICEMC, in cooperation with the Emergency Department Nurses Association, N.J. Chapter, has been conducting a highly successful training program for emergency department nurses and one of the first of its kind in the nation. This program was approved for a federal grant for a two-year period. Using an EDNA outline previously developed under a Federal grant, the ICEMC training committee developed a curriculum consisting of 160 hours of didactic instruction and 40 hours of supervised inservice education in hospital emergency departments. All subjects concerned with emergency medicine are taught and with the use of all types of training aids. The last cycle of instruction for the two-year period will start on March 5, 1979. All courses have been given in the following schools of nursing and under the supervision of a Nurse Training Coordinator: School of Nursing, The Mountainside Hospital, Montclair, Saint Francis Medical Center, Trenton; Helene Fuld Medical Center, Trenton, and West Jersey Hospital, Camden. The success of this program is indicated by the participation of 225 registered nurses working in hospital emergency departments and their endorsements. All graduates are receiving appropriate certificates for academic use. The Commission has approved continuation of this two-year program and has submitted a grant application for a two-year renewal grant.

Filed in accordance with the recommendation of the Reference Committee.

The Reference Committee noted that there was concern that transportation to hospitals is delayed so as to wait for the MICU unit and that members of these units are administering medication without proper authorization.

Medicine and Religion

Thomas H. McGlade, M.D., Chairman, Camden

(Reference Committee "D")

The Special Committee on Medicine and Religion reviewed and evaluated the 1978 Program and Annual Prayer Breakfast.

It was decided that the Third Annual Prayer Breakfast would be a buffet to expedite both the service and the program. An outstanding speaker will be presented in addition to appropriate readings from the Old and New Testaments by Society members.

A good attendance will insure the success of this special breakfast.

Filed in accordance with the recommendation of the Reference Committee.

Resolution

#15

Support for the Present Basic Nursing Education Programs

From the Camden County Medical Society

(Reference Committee "D")

Whereas, in October 1978 the New Jersey State Nursing Association which represents only 7.8 percent of New Jersey's licensed registered nurses voted to support the proposal that by January 1, 1985 the entry level into the professional practice of nursing in New Jersey shall require a Bachelor of Science degree in nursing; and

Whereas, at present 70 percent of nursing care in almost all of New Jersey's hospitals is delivered by graduates of diploma programs in nursing and these registered nurses are constantly advancing their knowledge; and

Whereas, many diploma schools which provide these nursing graduates will be forced to close or drastically modify their programs if the entry level shall be the Bachelor of Science degree, especially since funding of these hospitals by the State of New Jersey will be jeopardized; and

Whereas, experience has demonstrated that the existing level of entry into the nursing profession long has provided the skilled, dedicated, knowledgeable, and effective beginning professionals; and

Whereas, large numbers of highly committed, competent individuals would be lost to nursing through lack of financing and need to be gainfully employed as quickly as possible; now therefore be it

RESOLVED, that the Medical Society of New Jersey voice its support for the present programs, including the practical nursing program, the diploma school nursing program, the associate degree program, and the bachelor degree program to allow maximum variety of specialization of nurses needed in our complex health care environment; and be it further

~~RESOLVED, that the Medical Society of New Jersey continue to support the existence of present basic nursing education programs with the understanding that the curriculum will be changed as necessary to meet society's changing needs; and be it further~~

Amended by Reference Committee to read:

RESOLVED, that the Medical Society of New Jersey voice its support, and actively support the expansion of such programs, including the practical nursing program, the diploma school nursing program, the associate degree program, and the bachelor degree program to allow maximum variety of specialization of nurses needed in our complex health care environment; and be it further

RESOLVED, that copies of this resolution be sent to the Governor of New Jersey, the Commissioner of Education, the New Jersey Senate and Assembly, and to the press.

Adopted as amended by the Reference Committee.

Edward A. Schauer, M.D., Monmouth
Chairman
John R. Doyle, M.D., Bergen
James E. Brennan, M.D., Camden
David Sharp, M.D., Hunterdon
William E. Ryan, M.D., Mercer
David Gehring, M.D., Gloucester
Alternate Member

Reports:
Board of Trustees' Item
Council on Legislation
Council on Public Relations
Resolutions #16, #17, #18, #19, #30

Board of Trustees' Item

S-3110—ABUSE OF THE ELDERLY (Reference Committee "E")

S-3110 provides a protection system centered upon reporting by professionals of instances of persons responsible for the custodial care of the elderly who have abused or exploited those left in their care.

This legislation previously was given conditional approval by the Board on the basis that mandatory reporting of

instances of abuse should not be limited to physicians. Through the efforts of the Society's outside lobbyists, the requirement for mandatory reporting has been deleted from the bill. For this reason, the Society's position has been changed to one of approval.

Filed in accordance with the recommendation of the Reference Committee.

Legislation

Daniel J. O'Regan, M.D., Chairman, Jersey City

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern during the second session of the 1978 Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings.

Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's official intermediaries with New Jersey specialty societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields. The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to

select a representative.

Of the bills reported to the House in 1978, the following were signed into law:

APPROVED

- A-32 — Authorizes counties wherein there is no county home or hospital suitable for children afflicted with Tay-Sachs disease to appropriate \$5,000 per year for expenses incident to the diagnosis and treatment of those children residing in that county.
- A-65 — Permits county assistance for the care of children afflicted with Tay-Sachs disease.
- A-254 — Mandates school boards to conduct annual examinations of pupils to detect scoliosis.

POSITION CHANGE

- S-279 — **Ewing—Ancillary Services**—Authorizes the physician to delegate performance of limited procedures to certified technical aides. **APPROVED**

The following bills of medical interest were introduced in the 1978 Legislature, but too late to be reported to the 1978 House of Delegates:

S-407 — Hagedorn—Mental Health Services

Creates a ten-member commission to study and recommend extensive revisions to the mental health services delivery system in New Jersey as well as an indepth analysis of the impact of federal funding. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

S-440 — Dodd—Catastrophic Health Insurance

Creates a catastrophic health insurance fund to reimburse individuals for catastrophic costs incurred because of injury or illness. The fund is to be capitalized initially by the State who then would bill private carriers for their insureds. The carriers then would be permitted to recapture losses by placing surcharges on their policies. All of the mechanism is to be monitored by the Insurance Depart-

ment and administered via a "Health Insurance Underwriting Association." **DISAPPROVED**, because, although MSNJ approves the concept of catastrophic health insurance, this bill would change the insurance companies into fiscal intermediaries, if not sound fiscally, and could prove counterproductive.

S-497 — Greenberg—Professional Licensing Boards

Grants the Attorney General concurrent jurisdiction with the professional boards when, after notice, a given board has failed to execute its legal responsibility. Additionally, provides for uniform enforcement powers and procedures among the various boards. This legislation would not appear to impact severely on a reasonable and active professional board. **LAW c. 73 ('78)**

S-523 — Feldman—Data Privacy

A State version of the Federal Privacy Act, this bill grants individuals access to their personal information held in state government files. At the same time it obligates the state to prevent the misuse of private or confidential information and makes the government subject to civil suit.

An information data system would be created to classify the data being retained and stored by the state. **APPROVED**

S-653 — Hagedorn—Involuntary Commitments

Restructures existing laws to provide that:

1. The Boards of Freeholders shall designate one or more screening centers within their counties or on an inter-county basis as the Department of Human Resources may approve.

2. The screening service shall provide examinations, diagnoses evaluation, and emergency treatment in accordance with departmental regulations.

3. Involuntary commitments are to be certified to by two psychiatrists or one psychiatrist and one licensed physician or a psychiatrist and a psychologist.

4. The screening or commitment process is to be initiated by a sworn document signed by an immediate family member, next of kin, physician, psychiatrist, county medical examiner, social worker, police official, county prosecutor, or a county or municipal welfare director.

5. Screening services shall hold persons determined to be dangerous for no more than seventy-two hours before the involuntary commitment mechanism must be complied with.

6. Patients being admitted to screening centers or institutions have a detailed list of rights including the immediate right to counsel. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

S-677 — Lipman—Hereditary Disorders Act

This bill requires the Department of Health to set up a program of assistance for New Jersey citizens who suffer from hereditary disorders such as Cooley's anemia, cystic fibrosis, sickle cell anemia, galactosemia, hemophilia and Tay-Sachs disease. The program would include the development of:

1. Standards for detecting hereditary disorders
2. Voluntary testing and genetic counseling services
3. Laboratory services
4. An educational program concerning hereditary disorders
5. Curriculum guidelines (in cooperation with the Commissioner of Education) concerning the "nature, detection, prevention, and treatment of hereditary disorders"; and

6. Efforts (in cooperation with the Commissioner of Insurance) to eliminate "arbitrary and unreasonable discrimination against carriers or victims" of these disorders in insurance policies. **CONDITIONAL APPROVAL**, pending the deletion of "such as" in the bill to eliminate the implication that the bill applies to all hereditary disorders.

S-703 — Skevin—Radiology Services

Permits radiologists to bill patients for x-ray interpretations for amounts that are not covered under the person's hospital service contract. **DISAPPROVED**, because the language contained in the bill is ambiguous and could be interpreted to preclude the physician from collecting a fair fee.

S-826 — Dodd—PKU Testing of Newborns

This bill has no effect on the existing mandated test system. **NO ACTION**

S-828 — Dodd—Dental Anesthesia

Prohibits dentists from administering a local or general anesthesia unless they have passed a course in anesthesia which has been approved by the New Jersey State Board of Dentistry. **DISAPPROVED**, because the rules and regulations adopted by the New Jersey Board of Dental Examiners to regulate the administration of general anesthesia would make this legislation redundant.

S-838 — Dodd—Licensing and Regulating of Respiratory Therapists

Provides for the licensing and regulation of respiratory therapists and technicians under the auspices of the State Board of Medical Examiners. Provision of services other than under the direction or supervision of a physician shall be cause for revocation of licensure. **DISAPPROVED**, because the Society is not in favor of further individual licensure of ancillary personnel that must be relied upon by the practicing physician. The answer to the problem is not to license them individually, but to recognize the right of the physician to utilize those personnel whom he recognizes as competent and for whom he assumes responsibility.

S-846 — Parker—Breath and Blood Determinations—Persons Suspected of Driving Under the Influence of Alcohol or Other Intoxicating Drugs

Grants immunity to physicians who take samples or make tests at the request of police when done in a medically acceptable manner, but not forcibly and against physical resistance. **APPROVED** (This bill is similar to **A-759—Hurley** and the Council directed that a letter be forwarded to each sponsor recommending that the bills be combined and reintroduced as one complete bill.)

S-865 — Dumont—Utilization Review

Permits all insurance carriers to examine the same information and medical data that is available to the utilization review committee and the attending physician. **DISAPPROVED**, because this bill would endanger the patient-doctor confidentiality mechanism.

S-890 — Gagliano—Risk Registry for Handicapped Children

Provides for the maintenance of a risk registry for "handicapped children" (under 21 with organic disease, defect, or condition which may hinder normal growth and development) and for "high risk children" (any infant liable to become handicapped under definition by rules and regulations of the Public Health Council).

Physicians (doctors of medicine, osteopathy, dentists, chiropractors, optometrists, and podiatrists) along with psychologists, nurses, and mid-wives shall file confidential reports with the registry detailing the symptoms of the handicap, or of the high risk, within thirty days of diagnosis. **DISAPPROVED**, because this subject is already covered by existing legislation.

S-898 — Dodd—Controlled Dangerous Substances

Decriminalizes marihuana possession in regard to the recreational use of marihuana and hashish since (according to the sponsor) scientific evidence "overwhelmingly proves that traditional beliefs of the ill effects of marihuana usage generally have been mendacious and medically erroneous." **DISAPPROVED**, in accordance with Resolution #8 adopted by MSNJ's 1978 House of Delegates. Also this bill would lead the public to believe that there are no ill effects from the usage of marihuana when, in fact, there is no scientific evidence to support such a statement.

S-990 — Skevin—Local Health Services Act

Exempts municipalities with a population of less than 15,000 from the requirements of implementing the Local Health Services Act. **NO ACTION**

S-1038 — Bedell—Dental Practice

Would amend the existing statutes and existing common law to allow persons and organizations other than licensees to provide or offer dental services as long as the professional services actually are performed by licensees. **ACTIVE OPPOSITION**, because this bill would depart from existing New Jersey law and would place an added inflationary impact on the cost of health care services. It also would enable non-practicing individuals to profit from the conduct of a professional practice.

S-1042 — Bedell—Nursing Services (Blue Shield Coverage)

Permits policies at the option of the subscriber to provide direct reimbursement to nurses for nursing care if the nurse is not paid a salary by any health care provider for the duties so performed. **NO ACTION**

S-1043 — Bedell—Nursing Services (Individual Health Insurance Contracts)

Same as **S-1042** except it applies to individual commercial insurance contract benefits. **NO ACTION**

S-1044 — Bedell—Nursing Services (Group Health Insurance)

Same as **S-1042** except it is applicable to group health insurance contracts. **NO ACTION**

S-1053 — Maressa—Local Government Employee Coverage for Health Services

Allows local government entities to make direct payments to health and welfare plans rather than through insurance carriers. **CONDITIONAL APPROVAL**, pending an amendment to the bill that would allow the free choice of physicians, dentists, providers of services and health care facilities to employee beneficiaries.

S-1077—Weiss—Products Liability of Pharmaceutical Products
Requires all drug manufacturers in New Jersey to:

- carry products liability insurance according to minimum standards of the Insurance Commissioner
- provide products liability indemnity protection to each pharmacist retailing their products. **CONDITIONAL APPROVAL**, pending addition of the following amendment to the bill: "c. provide products liability indemnity protection to each physician prescribing or dispensing their products."

S-1110—Maressa, et al.—Abortions

This bill attempts to regulate abortions in some instances and to prohibit them in others. It provides:

(a) 1st trimester may be done electively by physicians after written consent of the patient. The informed consent involves:

(1) The diversity of dangers inherent in the abortion procedure, including but not limited to the possibility of immediate and long-term physical dangers, psychological trauma, sterility, increases in the incidence of premature births, tubal pregnancies, and stillbirths in subsequent pregnancies.

(2) The particular complications of the procedure to be used.

(3) Physical competency of the unborn child at the time the abortion is to be performed, and the specific biological facts concerning the development of the unborn child.

(4) Positive alternatives to abortion including childbirth and adoption.

There shall be an interval of not less than 48 hours between the time a woman signs the consent form and the abortion procedure is performed.

(b) After the 1st trimester abortions can be performed only after securing the informed consent detailed above and:

(1) Must be performed in hospital.

(2) A determination must be made whether or not the fetus is viable.

(3) If the fetus is viable the procedure must be necessary to preserve the health or life of the mother, and two other physicians must support that conclusion in consultation.

(4) All efforts must be used to preserve the life of a viable fetus and a second physician must be in attendance to assist the aborted fetus. **ACTIVE OPPOSITION**, as this legislation is an intrusion on the practice of medicine.

S-1192—Perski—Physicians' Assistants

Permits the use of physicians' assistants when the P.A. has a valid registration with the State Board of Medical Examiners, a protocol and job description filed with the State Board, supervision by a licensed physician. No physician may supervise more than one P.A. **ACTIVE OPPOSITION**, because licensure and/or registration of physicians' assistants will neither contribute to the quality of medical care nor decrease the cost of medical care.

S-1199—Dumont—Protection of the Elderly

Makes it a crime to abandon, neglect, or abuse the elderly. Physicians and other practitioners (some licensed, some not licensed, and some no longer existing) who have reasonable cause to suspect that an elderly person (anyone over 60) has been abused, neglected, exploited, or abandoned or is in need of protective services shall report the same in any reasonable fashion to the Office of the Ombudsman for the Institutionalized Elderly within five calendar days. Failure to report carries a fine of \$500.

Persons reporting under the act are immune from civil or criminal liability unless they acted in bad faith, or with malice, or have committed perjury. **ACTIVE OPPOSITION**, the Board was not against reporting situations detrimental to the elderly, but disapproved of the mandatory aspect of the bill.

S-1223—Dorsey—Tort Immunity

Extends governmental immunities to private physicians performing services for public entities whether as volunteers or independent contractors. **APPROVED**

S-1234—Weiss—Consent to Elective Surgery

Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position, and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and reproduction. **ACTION DEFERRED**, pending further action from the Ad Hoc Committee consisting of Doctors Rush, Todd, Krueger, Parsonnet, and O'Regan.

S-1248—Orechio—Electrologist Licensing Act

Provides for the registration and licensing of electrologists under the rule and regulation of the State Board of Medical Examiners. Electrology is defined as the art which effects the permanent removal of superfluous hair from apparently normal skin of the human body by electrical, electronic, or other technical scientific methods approved by the Board. **NO ACTION**

A-3—Burstein—Wrongful Death Damages Related to Minors

Would expand existing laws on the measurement of damages in wrongful death actions of minors. It would permit compensation for the loss of the pecuniary investment of the parents including the costs of birth and rearing of the child. **NO ACTION**

A-247—Croce—Regulation of Insurance Rates

Would amend the insurance statutes to allow carriers to alter rates without the prior approval of the Commissioner. The Commissioner could "disapprove a rate" if the carrier does not file with the Department supportive documentation within thirty days of the effective date of the rate. **APPROVED**

A-426—Hardwick—Uniform Anatomical Gift Act

Requires the Division of Motor Vehicles to provide a place on the driver's license where the individual can designate himself as a donor under the Uniform Anatomical Gift Act. **APPROVED** LAW c. 181 ('78)

A-458—Jackman—Professional Boards

Provides uniform enforcement powers and procedures for professional boards. Grants the Attorney General the right to concurrent jurisdiction and also to override a given board decision when contrary to law or the weight of evidence contained in the record before the Board. **NO ACTION**

A-507—DiFrancesco—Child Abuse

Would make medical evidence of the existence of venereal disease in a child under 12 a rebuttable presumption of child abuse or neglect. **DISAPPROVED**, because this bill would presume guilt and would therefore be considered unconstitutional.

A-514—Villane—Residential Facilities for Psychiatric Patients

Requires the Department of Human Services to inform the local health agencies whenever it places former psychiatric hospital patients in a local residential facility. **APPROVED**

A-521—DiFrancesco—Involuntary Commitments for Mental Disorders

Same as S-653. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-612—Jackman—Optometry

Makes it a violation of law for an optometrist to locate a practice within geographical proximity to a retail optical outlet so as to induce patronage to himself thereby. **NO ACTION**

A-622—Herman—Prescription Drugs

Amends existing law to permit patients to possess a ten-day's supply of a controlled dangerous substance in a container other than the original, provided the patient carries with him a writing provided by his physician detailing—the name and address of the dispensing practitioner, the prescription record identification number, the name, address, and registration number of the prescriber, the name of the substance, and the directions for its use. **APPROVED**

A-639—Baer—Medical Reports

Makes it a misdemeanor for a physician intentionally to supply a misleading medical report which is submitted to any judicial or administrative hearing in this State or used in negotiations seeking a settlement in any such proceeding. **APPROVED**

A-668—Pellecchia—Medicaid

Amends the Pharmaceutical Assistance to the Aged Program to include the disabled (i.e., those receiving Social Security total disability benefits). **NO ACTION**

A-708—Shapiro—Expunging of Mental Health Commitment Records

Provides that patients must be discharged in an improved condition or in a condition of remission before being eligible for expungement proceedings. **ACTION DEFERRED**, pending further information from the Council on Mental Health. LAW c. 163 ('78)

A-745—Burstein—Criminally Insane Persons

Makes determination of fitness for trial and also the continuing defense of insanity a purely judicial determination. If, however, the individual is ruled sane at the time of trial the jury then rules on the defense of insanity at the time of the commission of the offense.

Any time the defense of insanity at the time of the commission of the crime is the final determination, the State may request a sixty-day confinement for observation following which a hearing will be held to determine whether or not the individual can be released without being a danger to himself or others. That hearing is a

judicial determination. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-747 — Cowan—Medicaid

Makes disabled persons (eligible for benefits of permanent disability under the SSA) eligible for the State Pharmaceutical Assistance Program. **NO ACTION**

A-759 — Hurley—Motor Vehicles

Provides for implied consent to the taking of blood and urine samples for chemical analysis to determine drug content. Samples may not be taken forcibly and against the physical resistance of the person being arrested. **APPROVED**. (This bill is similar to S-846—Parker and the Council directed that a letter be forwarded to each sponsor recommending that the bills be combined and reintroduced as one complete bill.)

A-775 — Bornheimer—Nursing Services

Provides for elective group health insurance coverage of the fee-for-service nursing provided the nurse is not a salaried employee for the duties performed. **APPROVED**

A-776 — Bornheimer—Nursing Services

Same as A-775 except it extends coverage availability under medical service contracts. **APPROVED**

A-777 — Bornheimer—Nursing Services

Same as A-775 except it applies to individual health insurance contracts. **APPROVED**

A-800 — Orechio—Clinical Laboratory Services

Provides that laboratory services must be billed directly to patients except when billed to:

- a. the legal representative of services
- b. the insurance carrier designated by the recipient
- c. a hospital on behalf of the recipient
- d. an industrial firm on behalf of its employees
- e. a trade union health facility for its registered patients
- f. governmental agencies on behalf of the recipient
- g. a registered laboratory to another laboratory for actual services rendered

h. a physician who discloses to the recipient the name of the laboratory, the amount paid, and the processing or procurement charge. **NO ACTION**

A-817 — Orechio—Eye and Ear Examinations of School Children

Mandates Boards of Education to employ one or more optometrists to be known as the "school vision examiners" and one or more physicians to be known as "school hearing examiners." (The hearing examiners also may be the medical inspectors). **DISAPPROVED**, because the school physician already has the obligation to screen for physical defects including impairment of vision and hearing.

A-832 — Orechio—Eye Examinations of School Children

Mandates Boards of Education to employ one or more optometrists or physicians as "school vision examiners." **DISAPPROVED**, because the school physician already has the obligation to screen for physical defects including impairment of vision.

A-864 — Brown—Smoking

Requires health care facilities to set aside not less than 30 percent nor more than 50 percent of total patient rooms as "no smoking allowed" rooms. **APPROVED**

A-942 — Burstein—Medical Malpractice Reinsurance Plan

Amends the existing reinsurance facility law to recognize traditional insurance techniques for the determination of losses for those persons insured through the State facility. Allows the facility to write insurance directly. Losses would be made up by surcharge levies made against persons holding insurance through the facility. **NO ACTION** LAW c. 153 ('78)

A-945 — Burgio—Medicaid

Requires annual audits of all providers of services under the Medicaid Program insofar as financial records related to Medicaid eligibles are concerned. **NO ACTION**

A-957 — Newman—Workmen's Compensation (Free Choice of Physician)

Allows injured workers to select, upon notice to their employer, their own physician or hospital for the treatment of covered injuries. **APPROVED**

A-1024 — Bornheimer—Over-the-Counter Drugs

Requires all over-the-counter drugs to be labeled with an expiration date in regard to safety or efficacy. **NO ACTION**

A-1064 — Pellecchia—Ophthalmic Technicians

Repeals existing licensing laws related to ophthalmic technicians since they are mere production employees and have no real patient contacts. **NO ACTION**

A-1065 — Pellecchia—Medicaid

Expands Medicaid eligibility to those persons whose income and

resources place them at less than one and one-third times current eligibility ceilings. This would not produce a drastic expansion in the scope of the covered population. **APPROVED**

A-1071 — Hurley—Withholding or Withdrawing of Life Sustaining Procedures in Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive.

"Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only to prolong artificially the moment of death where in the judgement of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **APPROVED**

A-1095 — Gormley—Tay-Sachs Screening

Allows counties to appropriate annually up to \$10,000 to support voluntary Tay-Sachs screening and counseling programs. Matching state aid is to be made available via the Department of Health. **APPROVED**

A-1105 — Lesniak—Informed Consent for Elective Surgery

Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position, and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and reproduction. **ACTION DEFERRED**, pending further action from the Ad Hoc Committee consisting of Doctors Rush, Todd, Krueger, Parsonnet, and O'Regan.

A-1110 — Visotcky—Second & Third Surgical Opinions

A-1111 — Visotcky—Second & Third Surgical Opinions

A-1112 — Visotcky—Second & Third Surgical Opinions

These bills require Blue Shield, individual health insurance contracts, and group health insurance contracts to require second opinions in all elective surgical cases as a precondition to payment.

In addition, when the first and second opinions differ the contract shall provide for a third opinion should the patient so desire one. **DISAPPROVED**, the patient should be given the option of whether or not to seek a second or third opinion at the expense of the insurance carrier.

A-1116 — Stewart—Joint Underwriting Associations

Grants civil immunity to the Insurance Department and insurance companies participating in the various joint underwriting associations which are or may become operative in New Jersey. **NO ACTION**

A-1119 — Jackman—Chiropractic

Creates a separate chiropractic licensing board within the Division of Consumer Affairs and transfers all functions of the State Board of Medical Examiners related to the regulation of chiropractic to the newly created board. It does not change the definition of chiropractic nor the scope of practice. **DISAPPROVED**, because this bill would be unnecessary legislation.

A-1123 — Weidel—Withholding of Life Sustaining Procedures in Event of Terminal Illness

Same as A-1071. **APPROVED**

A-1132 — Weidel—Blood Donations

Provides for a \$25 deduction from gross income for each pint of blood a given taxpayer donates to nonprofit blood-collecting organizations. **APPROVED**

A-1155 — Deverin—Arrests of Apparently Intoxicated Persons

Requires police officers when making arrests of apparently intoxicated persons to examine those persons for the presence of medic alert bracelets or other forms of identification. **APPROVED**

A-1285 — Deverin—Abortion

Attempts to regulate abortions. During the first trimester the physician must secure written consent of the patient which demonstrates that she has been advised of the inherent dangers in abortions, dangers to the unborn fetus, and alternatives to abortion. Abortions could not be performed until 48 hours after the consent was obtained.

After the first trimester the physician must advise that a live-born infant may result; that the abortion must be performed in a hospital. If the abortion is not necessary to preserve the life or health of the

mother, it cannot be performed until the attending physician certifies with reasonable medical certainty whether or not the "unborn child" is viable. If the "unborn child" is viable the physician may not perform the abortion unless medically necessary to preserve the life or the health of the mother and only after consultation with two unrelated physicians.

If the "unborn child" is viable a second physician must be in attendance and care must be taken to preserve the life of the "unborn child."

No such "live-aborted" infant may be used for experimentation or research. **ACTIVE OPPOSITION**, as this legislation is an intrusion on the practice of medicine.

It was noted by the Reference Committee that the reason for active opposition was the feeling that this bill would represent an intrusion into the private practice of medicine, a position not related to an opinion on abortion itself.

A-1286—Stewart—Automobile No-Fault Insurance

Restructures the No-Fault Law to create the hopeful expectation of a viable and flexible commercial market. The section of this bill of interest to the medical profession is that which would empower the Insurance Commissioner to create regional review boards to promulgate schedules of reasonable fees for medical services for the most common forms of injuries. These schedules shall constitute maximum payment schedules for insurers. The boards may waive the scheduled fees when special circumstances require departure from such schedules. Claims presenting a question of fraud are to be referred to the Attorney General.

The review boards shall consist of two physicians, two attorneys, two insurance executives, and one public member. **CONDITIONAL APPROVAL**, provided the bill is amended to include the usual and customary fee schedule.

A-1294—Bornheimer—Insurance Payments for Dental Services

A-1295—Bornheimer—Insurance Payments for Dental Services

A-1296—Bornheimer—Insurance Payments for Dental Services

This three-bill package requires insurers to reimburse patients for services performed by dentists, if such services are covered when provided by physicians. (Blue Shield-Group Contracts-Individual Contracts). **APPROVED LAW c. 187 ('78)**

A-1314—Hurley—Physicians' Assistants

Provides for legal recognition of a physician's assistant who is duly registered with the State Board of Medical Examiners and provides certain services under the supervision of the employing physician. (Supervision means specific direction, but does not require the physician to be on the premises at all times.) **CONDITIONAL APPROVAL**, requiring modifications to preserve quality care and reduced costs.

Reference Committee noted that an entirely different position now has been taken by the Medical Society of New Jersey—one of active opposition.

A-1321—Orechio—Cardio-Pulmonary Resuscitation

Requires school boards to offer CPR as a mandatory course for all high school students. **ACTION DEFERRED**, pending further information from the Committee on Emergency Medical Services.

A-1351—Bassano—Advertising by Professionals

Deletes any jurisdiction over licensee advertising by the State Board of Medical Examiners or the Board of Psychological Examiners. **ACTIVE OPPOSITION**, because this bill takes away all restrictions and regulations with regard to advertising and precludes reasonable restraints which would be necessary to safeguard the public.

A-1387—Otowski—Physicians' Assistants (Same as S-1192) ACTIVE OPPOSITION, because licensure and/or registration of physicians' assistants will neither contribute to the quality of medical care nor decrease the cost of medical care.

A-1426—Lesniak—Commitment of Criminally Insane

Provides that the determination of the sanity of any confined person is an issue for the Court and not a jury. If the issue of insanity is raised at trial as a defense and the jury acquits a post trial hearing, the judge shall determine whether institutionalization or lesser restraints are indicated. Testimony of psychiatrists will be the controlling issue. **ACTION DEFERRED**, pending further information from the Council on Mental Health.

A-1441—Karcher—Peer Review Immunity

Grants civil immunity for peer review activities including those of professional societies. (Same as S-777) **ACTIVE SUPPORT**

PROFESSIONAL LIABILITY

Our complete professional liability practice is currently under review by the Governor to see whether or not we may secure administration support. Progress has been painfully slow.

Two other bills drafted and supported by the Medical Society of New Jersey have been introduced and are moving—S-777 (Peer Review Immunity) and S-1517 (Allowance of defense costs and attorneys fees).

Filed with notations on A-1285 and A-1314, in accordance with the recommendation of the Reference Committee.

Supplemental Report

In the afternoon of January 9, 1979, the Second Annual Session (1979) of the 198th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members consisting of 12 Republicans, 27 Democrats and one vacancy. The Assembly has a total of 80 members consisting of 26 Republicans, 53 Democrats and one vacancy. By means of official legislative bulletins the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

ACTIVE SUPPORT

All-out support of the measure

ACTIVE OPPOSITION

All-out opposition for the measure

CONDITIONAL APPROVAL

To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.

APPROVAL

Commended as satisfactory, but not actively supported

DISAPPROVAL

Rejected as unsatisfactory, but not actively opposed

N.B. The Board of Trustees, at its April 18, 1979 meeting, voted to amend the Council on Legislation's position on A-1110, A-1111, and A-1112 (Second and Third Surgical Opinions) from disapproved to **ACTION DEFERRED**, pending further study by the Council.

The Board also accepted the Council's recommendations on the following, previously reported **ACTION DEFERRED**, bills:

S- 515—Creates a Mental Health Study Commission consisting of 34 members to recommend to the Governor a comprehensive plan for delivering mental health services in New Jersey. **ACTIVE OPPOSITION**, because there have been a series of commissions to study and evaluate the State's institutions, agencies, and services for the mentally ill and to develop a State plan to expand and improve the delivery of mental health services. The most recent findings have been published in 1976. Based on that experience, it appears that an appointed commission, inadequately financed, as proposed in this bill, cannot successfully undertake a highly skillful and impartial study and evaluation.

We believe that an impartial study by trained persons outside of the direct State system of political and health care services is indicated and may be useful at this time. However, the format proposed in this bill, we believe, would be unproductive, a waste of taxpayers' funds and therefore, not beneficial to the public.

S- 653—To provide for a procedure for the involuntary commitment of the mentally ill. **DISAPPROVED**, in favor of **A-475**.

A- 708—Provides that patients must be discharged in an improved condition or in a condition of remission before being eligible for expungement proceedings. **APPROVED**

A-1105—Requires physicians to secure specific written consent to elective surgical procedures which shall indicate the operating surgeon and identify any other participating physicians. The primary surgeon must be in continuous attendance unless an emergency occurs in which event his absence shall be noted in the operative record. The operative record which must be kept shall indicate the name, position and duties of each person in attendance at such operation. This record must be available for at least one year at both the hospital and the physician's office and available for the patient's inspection and reproduction. **ACTIVE OPPOSITION**, because this bill is not consistent with good medical care, fails to recognize sound concepts in teaching programs, ignores the existence of the surgical team and does not demonstrate an awareness of the presence of the anesthesiologist and numerous assisting physicians.

A-1321—Requires school boards to offer CPR as a mandatory course for all high school students. **CONDITIONAL APPROVAL**, provided the bill is amended for the courses in CPR to be taught on a voluntary instead of mandatory basis.

On April 10, 1979, the following bill was signed into law as c. 68 of the Laws of 1979:

S- 865—Permits all insurance carriers to examine the same information and medical data that is available to the utilization review committee and the attending physician. **DISAPPROVED**, because this bill would endanger the patient-doctor confidentiality mechanism.

CURRENT STATE LEGISLATION

The Council offers this Supplemental Report #1 covering items dealt with since the compilation of its Annual Report.

S-1297—Orechio—Electrologists Licensing Act

Authorizes the State Board of Medical Examiners to license electrologists. An electrologist is "a person who professionally removes hair from apparently normal skin of the human body by electrical, electronic, or other technical, scientific methods approved by the Board." The advisory board is to consist of three electrologists and three medical doctors, preferably dermatologists. **APPROVED**

S-1511—Skevin—Controlled Dangerous Substances Therapeutic Research And Treatment

Creates a research program within the State Department of Health. Patients not responding to conventional therapy will be allowed into the program. Drugs currently on the Federal Drug Administration experimental list, i.e., marihuana, etc. will be utilized under Federal guidelines. The Medical Society of New Jersey will be given an active role, i.e., making recommendations to the Commissioner of Health for appointment to the Therapeutic Research and Treatment Qualification Review Board. **NO ACTION**

S-1517—Friedland—Payments of Attorneys' Fees in Civil Suits

Allows the Courts to award defense costs and attorneys' fees to successful defendants in situations where the court finds a professional liability claim or counterclaim to have been frivolous or repetitious or barred by the Statute of Limitations. **ACTIVE SUPPORT**

S-3007—Feldman—Cardiopulmonary Resuscitation

Requires recreational and athletic facilities to have at least one CPR-trained employee on premises at all regular operating hours. **NO ACTION**

S-3017—Scardino—Medical Service Corporations

Lowers the statutory level of "groups" from 100 to 50 as was done previously with Blue Cross. In this fashion, parameters of the two plans are similar. It will not permit, however, a group rating formula which produces a rate higher than the community rate. **APPROVED**

S-3026—Merlino—Hearing Examination

Requires school systems to conduct an annual screening of hearing programs in accordance with Department of Education guidelines. (The Medical Society of New Jersey's Committee on Hearing and Speech supports this bill.) **CONDITIONAL APPROVAL**

Adopted a recommendation of the Reference Committee to change the Society's position on this bill to CONDITIONAL APPROVAL for the reason that it is not specific in its referral of a child with a hearing problem, and it is the consensus that any such child should be referred to a physician for examination. The original recommended position on this bill had been "active support."

S-3065—Maressa, Cafiero, et al—Medical Education

Appropriates 8 million dollars for acquisition, renovation construction, in relation to the osteopathic facility in South Jersey. **ACTIVE OPPOSITION**, because the Medical Society of New Jersey is convinced that the construction of a basic science facility in South Jersey is an unnecessary expenditure and misdirection of State funds designated for medical education.

S-3070—Hirkala—Certificate of Need

Would exempt free-standing bio-analytical laboratories, which deal primarily in interstate commerce, from the certificate of need law. **DISAPPROVED**

Adopted a recommendation of the Reference Committee to change the Society's position on this bill to DISAPPROVED for the reason that it is discriminatory with reference to the difference in types of bioanalytical laboratories. The original position recommended on this bill had been "no action."

S-3110—Scardino—Health and Safety of the Elderly

Provides a protection system centered upon reporting by professionals of instances of persons responsible for the custodial care of the elderly who have abused or exploited those left in their care.

Reports are to be made to the Office of the Ombudsman for the Institutionalized Elderly upon reasonable cause. The reports are to be confidential and the person making such a report is granted civil and criminal immunity provided they have not acted in bad faith or with malicious purpose. **CONDITIONAL APPROVAL**, on the basis that the law should apply to everyone and not be limited to physicians. Further, the word "exploitation" should be more clearly defined.

A-1618—Muhler—Eyeglasses-Contact Lenses

Requires physicians and optometrists to supply patients with written lense prescriptions so they may purchase from the dispenser of their choice. **ACTIVE OPPOSITION**, to that portion of the bill referring to contact lenses because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist.

A-1682—Shapiro—Medical Education

Appropriates 2.15 million dollars to construct a 33-bed psychiatric hospital at CMDNJ-Newark. **NO ACTION** law c. 138 ('78)

A-1686—Herman—Emergency Medical Services

Extends the pilot program in mobile coronary intensive care units to June, 1979. **NO ACTION** law c. 132 ('78)

A-1689—Burstein—Pharmaceutical Assistance to the Aged

Grants the Commissioner of Human Services regulatory control over the Pharmaceutical Assistance to the Aged Program in order to "control costs." **NO ACTION**

A-1763—Bassano—Controlled Dangerous Substances Research

Authorizes the Department of Health to conduct research into the efficacy of some drugs currently on the banned Schedule I list. **NO ACTION**

A-1779—Herman—Medicaid

Extends Medicaid eligibility to those currently not eligible if they encounter a catastrophic illness which means "any illness or injury requiring inpatient care in a hospital or skilled nursing facility, the costs of which exceed 25% of the person's annual net income in excess of the applicable categorical assistance eligibility level, whichever is less." **APPROVED**

A-1780—Lesniak—State Board of Medical Examiners

Provides that State Board of Medical Examiners may discipline physicians who charge excessive or unreasonable fees. **NO ACTION**

The Reference Committee noted that some of those at the hearing felt the State Board of Medical Examiners should not have this authority to discipline physicians. However, the feeling of the Reference Committee was that this might be a good function of the State Board if it could be utilized as backup for the actions of medical societies and their judicial councils and committees.

A-1851—Kavanaugh—Controlled Dangerous Substances Research
Same as S-1511 but restricts the products which may be used to marihuana and tetrahydrocannabinols and its derivatives. **NO ACTION**

A-1863—Maguire, Gallo—Medicaid Appropriations
Transfers six million dollars from the general Medicaid budget and four million dollars from the AFDC Program to the Pharmaceutical Assistance For the Aged Project. **NO ACTION**

A-1893—Bassano—Controlled Dangerous Substances Research
Creates a research program within the State Department of Health. Patients not responding to conventional therapy will be allowed into the program. Drugs currently on the Federal Drug Administration experimental list, i.e., marihuana, etc., will be utilized under Federal guidelines. The Medical Society of New Jersey will be given an active role, i.e., making recommendations to the Commissioner of Health for appointment to the Therapeutic Research and Treatment Qualification Review Board. **NO ACTION**

A-3003—Fortunato—Special Hospitals Emergency Services
All special hospitals would be required to provide full-time emergency services coverage. **ACTIVE OPPOSITION**, because the context of the bill is not clearly defined, i.e., (What is meant by resident physician?, etc.), plus the cost implication would defeat the purpose of the bill. There are twenty-two hospitals licensed as "special hospitals" within the State that have arrangements for a physician to be on call at all times, but they are not physically present.

A-3011—Schwartz—CAT Scanners—Certificate of Need
Requires that a certificate of need be secured for the operation of

all CAT units. **ACTIVE OPPOSITION**, because the physicians in their private practices are currently exempt from the certificate of need and should continue to be so. Physicians do not enter into public fund raising, are not exempt from taxes and are placing their own resources at risk. Further, they would be at a distinct disadvantage in trying to compete with hospitals for a certificate of need.

A-3014—Bassano—Marriage Licenses
Requires all female applicants under 45 years of age for a marriage license to show laboratory evidence of a rubella response test as a condition precedent to the issuance of a marriage license. The physician is to inform the applicant of the medical significance of the results of the serological test. **NO ACTION**

Adopted a recommendation of the Reference Committee that the matter of rubella testing and the issuance of a marriage license be considered by obstetricians, pediatricians, and family physicians, and that they should offer their counsel to the Council on Legislation. The House referred A-3014 back to the Council on Legislation for further consideration and consultation with these groups.

A-3043—Bassano, Maguire—New Jersey Controlled Dangerous Substance Act

This bill permits duly authorized agents, officers or employees of an incorporated humane society to buy, possess, and use sodium pentobarbital to euthanize injured, sick, homeless, and unwanted dangerous pets or domestic or wild animals. **NO ACTION**

A-3103—Costello—Education
Grants parents the right to have their children excused from health, family, or sex education classes and also drug education classes on the basis of religious or moral beliefs. **NO ACTION**

Filed in accordance with the recommendation of the Reference Committee.

Public Relations

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "E")

The Council on Public Relations has continued its policy to respond to the mandates of the House of Delegates as well as to adapt to the PR needs of the Medical Society of New Jersey's membership.

Continuing Projects:

- a. Publication and distribution of:
 - (1) *Membership Newsletter*
 - (2) Monthly news media releases on public health and professional liability (statewide newspapers, radio and TV).
- b. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interest, and activities, including:
 - (1) The Eye Health Screening Program
 - (2) The Annual Meeting
 - (3) Child Safety Week
 - (4) Selected official programs and activities
 - (5) Professional Liability—through newspaper articles explaining MSNJ's position on professional liability and the problems that are being reflected on patient care.

- (6) Legislative Meetings—between MSNJ representatives and legislators regarding medical and health-related matters, such as professional liability, cost containment, and peer review. These meetings were also of value to promote rapport and better understanding through communication with the legislators.
- (7) Continuing the work of reestablishment and updating the legislative keymen system for legislative public relation activities.
- (8) JEMPAC—continued cooperation with the JEMPAC Committee in the preparation and dissemination of promotional material on JEMPAC needs and activities.
- (9) Coordinated effort of the Council on Public Relations with the Ad Hoc Committee on Drug Abuse for future MSNJ involvement in drug abuse education and prevention.
- c. The Information Center at the Annual Meeting for the issuance of press releases.
- d. The Golden Merit Award continues as an important function in recognizing the physicians in the state who have

served 50 years or more. In, 1978, 81 awards were bestowed, making it a grand total of 1,090 since the awards inception in 1957.

e. Encouragement of the continuance—or establishment—of orientation programs for new members under the sponsorship of component societies.

f. Encouragement of statewide emergency medical care coverage, particularly with reference to "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the Appendix Reference Information of the *Membership Directory*.

g. Encouragement of increased voluntary blood donations.

h. Encouragement of radio broadcasts under the auspices of component medical societies, as well as from the State Society.

i. Encouragement of medical TV programs of informational value to the public.

j. Diabetes Detection Week.

k. Placement services in *The Journal*.

The Staff has met with the personnel of CBS in New York to discuss possible public interest subjects for future TV programs.

Twenty-six newspapers throughout the State have carried monthly releases on the progress of medicine, the problems of medicine, and the professional liability issues. Many of the messages that appeared in the newspapers as advertisements (as public service activities of the Society) also appeared in *Time*, *Newsweek*, *Sports Illustrated*, and the *U.S. News and World Report*.

STATUS REPORT

Newspapers—During the past year we have dealt with such public service topics as "Emergency Treatment for Poison Control," "Obesity," and the "Running Craze." There were two ads about national health insurance and six were about professional liability problems.

Magazines—*Time*, *Newsweek*, *U.S. News & World Report*, *Sports Illustrated*, and *New York Magazine*.

In August 1978 we ran a professional liability ad titled "Hit The Jackpot." This month's subject is national health insurance and we are scheduled for another professional liability ad, "Second Opinion," in May.

Direct Mail—Each member of the Society receives two mailings per year. In 1978 the members were mailed a four-color poster dealing with professional liability titled "Going Out of Sight." They also received a four-color poster titled "Running Craze."

Television—During 1978, Public Service Announcements were aired out of New York, and Philadelphia television stations including the major network affiliates. This is the only effective way to reach our New Jersey population via television. The 30-second public service announcements were run at all time periods including prime time and included treatment of the following subjects:

- a. First Aid for Choking (Heimlich Maneuver)
- b. Obesity
- c. Emergency Poison Treatment
- d. Jogging
- e. Doctor Todd's Professional Liability Spot

Radio—In an effort fully to cover the State of New Jersey via the radio waves, public service announcements were mailed to ninety-five radio stations in New Jersey, Pennsylvania, New York, and Delaware. One of the public service announcements offered a question and answer booklet dealing with professional liability. Others were titled "The Running Craze," "Hazards of Marihuana," "Hit The Jackpot," "One False Move and I'll Sue," "Doctor Todd's Message" and "Second Opinion."

The last four topics mentioned are concerned with professional liability. Radio coverage is more difficult to monitor than television coverage, however, we have reason to believe that the stations in general are cooperating.

Cornerstone Mailings—We prepared the copy and artwork for three direct mailings to the general membership for the purpose of seeking donations to help defray the cost of the House of Delegates' Room.

Physician's Assistant Survey—A statewide opinion survey of the membership regarding Physician's Assistant legislation was taken in September.

Benchmark Survey—A general survey of New Jersey's population was taken in April, 1978, to determine attitudes regarding health care in general and specifically regarding the membership.

Awards—Two of our ads and one of our television commercials were awarded trophies by the Advertising Club of North Jersey.

The Council agreed that all advertising, whether free or paid, should aim at:

- a. Improving our public image through information.
- b. Increasing physician participation in MSNJ activities.
- c. Improving physician attendance at county and state meetings.

The following is recommended to all our membership as incorporating the most effective methods for good public relations:

- a. Please read the literature distributed including the *Newsletter*, *The Journal*, and special releases. This would do most to relieve the so-called "communication gap."
- b. The county officers and secretaries should pass on to their membership the information contained in the minutes and other releases sent them.
- c. More of the membership should participate, at all levels, particularly in the political scene.
- d. Attendance at meetings of the presidents and presidents-elect should improve.
- e. Trustees should be invited to meetings of the county societies.
- f. Consideration should be given to county meetings with their local press representatives and with their local legislators.

Reference Committee reported that there were some negative feelings among those who attended the hearing concerning a group called the "Singing Physicians" who appear on a Blue Shield radio advertisement, and recommended that this possible problem be referred to the Council on Public Relations. Adopted by the House.

Report filed with commendation to the Council for its many activities in improving the status of the physician in the public eye, in accordance with the recommendation of the Reference Committee.

#16

Fund Family Practice Department

From the Essex County Medical Society

(Reference Committee “E”)

Whereas, there is and will be accentuated a shortage of family physicians in northern New Jersey; and

Whereas, this shortage only can be alleviated by the training of family physicians from the very start of their medical education; and

Whereas, said training programs need students indoctrinated in the concepts of family practice and strongly identified with the aims of family practice; and

Whereas, the thrust of such programs is to supply an acutely needed specialty in the various areas of New Jersey; now therefore be it

RESOLVED, that the Medical Society of New Jersey request the legislature of New Jersey specifically to mandate and fund a Department of Family Practice in the College of Medicine and Dentistry of New Jersey-New Jersey Medical School.

Rejected in accordance with the recommendation of the Reference Committee.

The Reference Committee recommended also that this problem be referred to the Board of Trustees of the Medical Society of New Jersey for consideration of other means of persuasion to develop a department of family practice at CMDNJ, New Jersey Medical School (such as different use of AMA-ERF funds).

Recommendation of the Reference Committee approved by the House.

#17

Legal Drinking Age

From the Bergen County Medical Society

(Reference Committee “E”)

Whereas, chronic alcoholism is a progressive, destructive disease recognized by the American Medical Association since 1956, and by the Bergen County Medical Society since 1965; and

Whereas, abusive drinking of alcoholic beverages among our teens is on the increase year after year; and

Whereas, despite our Society’s warning, the State of New Jersey lowered the drinking age from 21 to 18; and

Whereas, the free access to alcoholic beverages had a direct impact on the increase of traffic accidents, suicides, deaths, and crippling, disabling diseases among our children; and

Whereas, there is a steadily increasing movement in our community as expressed by the New Jersey Mayors Association, the State Safety Council, numerous coaches of athletic

teams in our schools, representatives of many municipalities, and legislators urging increasing the legal age of drinking back to 21; now therefore be it

RESOLVED, that the Medical Society of New Jersey endorses raising the legal age of drinking to the age of 21; and be it further

RESOLVED, that copies of this resolution be sent to members of the New Jersey Legislature and to the press so that the community can be informed of our commitment and responsibilities taken as physicians on behalf of the welfare of our children.

Adopted in accordance with the recommendation of the Reference Committee.

#18

Legislation To Prevent Damage to Physician-Patient Relationship by Insurance Companies and/or Governmental Agencies

From the Union County Medical Society

(Reference Committee "E")

Whereas, the physician is requested to provide information concerning his patients in their applications for insurance coverage and/or government benefits; and

Whereas, such medical information often provides a basis for adverse decision by the insurance company or government agency against the patient; and

Whereas, these entities frequently advise their clients that such adverse decisions are the responsibility of the physician who completed the application when, in fact, the physician did not participate in the decision-making process; and

Whereas, such allegations are damaging to the patient-physician relationship; now therefore be it

RESOLVED, that the Medical Society of New Jersey seek to initiate legislation to prevent insurance companies and/or governmental agencies from phrasing their denial of coverage or benefits in such a way as to cause the patient to believe his physician actively participated in an adverse decision; such legislation to carry substantial penalties for violation.

Adopted in accordance with the recommendation of the Reference Committee

#19

Mandatory Installation of Seat Belts or Other Restraints on School Buses

From the Union County Medical Society

(Reference Committee "E")

Whereas, the matter of automobile and bus safety is an important public health matter; and

Whereas, the occurrence of school bus accidents is not entirely preventable; and

Whereas, the use of seat belts in automobile and bus

accidents has been proved to save lives; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the New Jersey legislature to make the presence of seat belts **or other restraints** in school buses mandatory.

Adopted with editorial changes, in accordance with the recommendation of the Reference Committee.

#30 Bioptic Lens

From John Scillieri, M.D., Delegate, Passaic County

(Reference Committee "E")

Whereas, there is no evidence that a driver wearing a bioptic lens is any safer than one with the same vision, without a telescope; and

Whereas, the bioptic lens has a small seven-degree magnified area of vision with a twelve-degree blind area around it; and

Whereas, this small island of vision is intended and useful only in viewing a stationary object with the viewer in a stationary position; and

Whereas, in a moving vehicle objects would be confusingly darting in and out of this small area of vision, making the driving of a vehicle hazardous to himself and equally hazardous to everyone else on the highway; and

Whereas, it is well known that candidates who use the bioptic

lens to "pass" the visual test for driving do not use them in actual driving of their vehicle; and

Whereas, the Department of Motor Vehicles has permitted a few candidates to pass the visual requirements with these lenses; and

Whereas, legislation is being introduced to legalize these lenses; now therefore be it

RESOLVED, that the Medical Society of New Jersey actively oppose any bill proposed by the legislature advocating the use of **any form of telescopic lens** as a means of "passing" the drivers' test in New Jersey.

Adopted with editorial changes in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "F"

Carolyn W. Watson, M.D., Essex

Chairman

Charles J. Moloney, M.D., Burlington

George T. Hare, M.D., Camden

Jeffrey M. Solomon, M.D., Cumberland

George A. Zazanis, M.D., Morris

Marc J. Crilly, M.D., Bergen

Alternate Member

Reports:

Board of Trustees' Items

Council on Medical Services and its

Special Committee on Occupational Health, Workmen's Compensation, and Rehabilitation

Committee on Medicaid

Membership Inquiry and Complaint Committees

Council on Mental Health

Ad Hoc Committee on Drug and

Alcohol Abuse

Committee on Impaired Physicians

Resolutions #20, #21, #22, #23, #24, #25, #32

Board of Trustees' Items

AMA DRAFT RESOLUTION ON COST CONTAINMENT (Reference Committee "F")

The Board voted to endorse the AMA's draft resolution on cost containment urging physicians to keep fee increases in line with the annual increase in the cost of living and to cooperate in restraining increases in hospital costs without arbitrary limits or government intervention.

Filed in accordance with the recommendation of the Reference Committee.

VOLUNTARY COST-CONTAINMENT COMMITTEE OF NEW JERSEY

(Reference Committee "F")

New Jersey's voluntary cost-containment effort grew out of a challenge issued to hospitals in November, 1977 by Congressman Dan Rostenkowski, Chairman of the Subcommittee on Health of the Committee on Ways and Means. Congressman Rostenkowski challenged the industry to develop and implement a program for effective voluntary restraints as an alternative to the hospital cost containment legislation being considered by Congress. The American Hospital Association, the American Medical Association, and the Federation of American Hospitals formed a National Steering Committee called the Voluntary Effort. The national committee, in turn, urged each state to set up its own cost-containment committee. Thirteen members representing both hospitals and physicians, compose the membership of the Voluntary Cost-Containment Committee of New Jersey.

At the initial meeting, the Committee discussed the directions of the cost containment efforts for New Jersey. It was concluded that New Jersey's effort would differ from the national objective of the Voluntary Effort, which is to reduce the rate of inflation by two percent per year. The Committee determined that it should establish task forces, to develop specific action recommendations which can impact upon costs for major subject areas.

The following recommendations, which were supported by the Board of Trustees, are the result of careful study and deliberation by the Committee, as well as by members of seven task forces which explored more specific areas. In examining the complex problem of how increases in health costs can be restrained in New Jersey, input was available from hospital administrators, physicians, other health care

professionals, industry, insurance carriers, and governmental officials.

1. Support the efforts of the New Jersey Department of Human Services to obtain a waiver from the Department of Health, Education, and Welfare to allow hospitals to be paid by the Medicaid Program appropriate long-term care rates for those patients who no longer require acute-care services but for whom no long-term care beds are available. In addition, there should be a waiver mechanism established by the New Jersey Department of Health permitting hospitals voluntarily to convert unneeded acute-care beds to long-term care beds.

2. The Department of Health, Education, and Welfare (HEW) and the Office of Management and Budget should examine the issues relative to the End-Stage Renal Disease Program and remove from the program all duplicative and counterproductive regulations and reporting requirements. If necessary, they should recommend legislative modifications to achieve the least costly and most efficient data collection reporting and processing system.

3. HEW should support the gradual expansion of the mandate of Professional Standards Review Organizations initially to include monitoring the care received by all hospital patients, and later, the care rendered in all sites for health care delivery. New patient care review activities should be phased in only after their effectiveness has been evaluated and demonstrated, and any new activities should be funded adequately.

4. HEW should require Professional Standards Review Organizations to report annually and make public their status relative to relationships with physicians and institutions and their status and coordination with other regulatory bodies. These reports should preserve the confidentiality of identifiable personal health-related information in the absence of an authorized release of such information by each affected patient, practitioner, and institution.

5. As a primary cost-containment effort, the New Jersey Hospital Association, as a top priority, should have a strategy, attacking statutes and regulations which interfere with the governance structure and day-to-day management of hospitals. These laws are generally costly, unnecessary, and have little or no effect in enhancing quality of care.

Such a strategy should include the following:

a. Arrange for discussions between interested parties and

agency staff during regulation development.

b. Provide staff regulations and policies to interested parties for review prior to publication.

c. Review regulations after they are implemented to check on their effectiveness.

6. As a major cost-containment effort, support the American Hospital Association's position that it should continue to maintain and strengthen its capability to monitor the development of legislation and regulations, develop legislative proposals, monitor and analyze the matters involved, inform and, when appropriate, counsel allied associations and membership, and develop and present appropriate comments and recommendations to Congress and regulatory agencies.

7. Support the American Hospital Association's Board of Trustees' recommendation that all hospitals and allied hospital associations should participate actively in the American Hospital Association's Partnership for Action Program in order to implement fully and improve hospital participation in the legislative and regulatory process.

8. Support the American Hospital Association's Board of Trustees' recommendation that all hospitals and allied associations should work actively with the American Hospital Association to analyze the impact of regulations and bring to the attention of appropriate agencies instances where the regulations have had adverse effects and propose recommended solutions.

9. The Commissioner of Insurance should provide that insurance companies use the Building Officials and Code Administrators Basic Building Code (BOCA) rather than the National Building Code. BOCA Basic Building Code is more consistent with hospital life Safety Code standards.

10. All hospital licensure standards for the Department of Health should be revised to conform with state and federal laws and regulations. This action would eliminate some critical conflicting standards that currently are applied to hospitals.

11. The Medical Society of New Jersey and NJHA should explore the cost-restraining potentials of the "physician extender" concept.

Filed in accordance with the recommendation of the Reference Committee.

DISPUTED CLAIMS COMMITTEE

(Reference Committee "F")

The President and Executive Director met with representatives of the New Jersey Hospital Association and Blue Cross and Blue Shield to develop a methodology for processing disputed claims. A variety of concepts, including the current committee, were discussed. The consensus was that there should be a committee appointed by the Medical Society with the concurrence of the New Jersey Hospital Association. The members would be practicing physicians from various disciplines. In addition, the chairman of the committee would have the ability to designate a specialist

(when necessary) as case reviewer so that each case, when reviewed by the committee at quarterly meetings, would receive full and fair recommendation.

The President was authorized to proceed with the appointment of the committee and a list of reviewing consultants.

Filed in accordance with the recommendation of the Reference Committee.

MODEL HEALTH CARE SYSTEM

(Reference Committee "F")

In November, the Board received as informative a report from the Task Force to Review the New Jersey Department of Health Model Health Care System, which elicited the following: There are problems in the health care system. There is needless waste, over-utilization, under-utilization, and misutilization. Quality is divergent, rarely uniform, and difficult to measure. In spite of success, there is room for improvement. In spite of failures, it is the best system available. Though the altruistic motivation of those rendering the services may be challenged, we indeed have the most cost-efficient system in the world.

The Model Health Care System, which is utopian in concept and not grounded in reality, and for which no strategy is outlined for implementation, deals with three concepts:

Part I—Resources and Services—This section provides cradle-to-grave universal coverage for all persons. It would relocate physicians and patients alike and evolves into a highly centralized, socialized, welfare state system that is not concerned with quality. Students selected to enter medical training will not be chosen on the basis of academic achievements but according to "other personal qualities."

Part II—Administration and Regulation—Espouses total central administration to decide how services are to be provided; to whom, by whom, how often, and at what charges. There are to be no considerations for experience, motivation, or initiative. Providers are relegated to technician status at fixed salaries.

Part III—Financing—Envisions a mandatory universal health insurance plan using a combination of general taxes and employer/employee payroll taxes. Supplemental benefits could be purchased from private insurers. The disbursing conduit would either be a public authority or fiscal intermediaries. Emphasis would be on primary care, early treatment, and outpatient services. Inpatient care and services are to be discouraged.

Since the preface indicates that the model is not constructed with a view toward reality or implementation, we must avoid the temptation to overreact. Conversely, it does give us some insight into what the State Department of Health has planned for our future.

Filed in accordance with the recommendation of the Reference Committee.

Medical Services

Victor H. Boogdanian, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of standards and character of medical practices in New Jersey, and the investigation of the economic and social aspects of medical care.

AD HOC COMMITTEE ON NUTRITION (Howard N. Jacobson, M.D., Chairman)

No formal report was given to the Council by this Committee.

BOARD OF TRUSTEES REFERRAL— HEALTH MANPOWER NEEDS—HENRY J. AUSTIN HEALTH CENTER

A survey was conducted of all primary care physicians in the "target area" in Trenton involving the Henry J. Austin Health Center. The results of that survey were discussed and considered and the Council recommended and the Board approved that the Medical Society of New Jersey disapprove the application of the Henry J. Austin Health Center for National Health Service Corps personnel.

BOARD OF TRUSTEES REFERRAL— COOPER MEDICAL CENTER AMBULATORY CARE INC.—NATIONAL HEALTH SERVICE CORPS

The Council reviewed the request regarding the application of the Cooper Medical Center Ambulatory Care, Inc. for assignment of National Health Service Corps personnel to their facility. The Council recommended and the Board approved that the Medical Society of New Jersey approve the Cooper Medical Ambulatory Care, Inc.'s application for National Health Service Corps personnel.

BOARD OF TRUSTEES REFERRAL— BASIC MEDICAL SCIENCE STRUCTURE OF SOUTH- ERN NEW JERSEY

Two conclusions were reached by the Council and contained in the Council's position paper that was approved by the Board of Trustees:

1. The Board unanimously agreed that there is a need for an increase in the basic science capability for 100 students in New Jersey to reach the number of 400 new physicians graduated each year.
2. The Board unanimously agreed that existing basic medical science facilities in Piscataway and Newark should be expanded.

Also, the Council felt that for the present, there should be no establishment of a basic science facility in Southern New Jersey. In due course of time, if it is necessary to establish such a facility, such a facility should teach both osteopathic and allopathic students. At the present time, the concept of a "school without walls" should be continued and the available facilities should be utilized to their fullest.

THIRD PARTY REIMBURSEMENT

The Council reviewed developing legislation which would equalize third-party reimbursement for medical services regardless of the type of facility rendering the care. This proposed legislation was presented by Mr. Steven Blader of the New Jersey Department of the Public Advocate. The

Council agreed that it should be assured that the type and place of medical care a patient will receive be left up to the physician and not a third-party carrier.

Mr. Blader pointed out that this legislation will necessitate a major change in the insurance industry's way of thinking in order to remove the present emphasis on hospital inpatient care in favor of the same procedures being done as outpatient services outside the hospital setting. He would like to see a solid groundwork laid for the establishment of outpatient services as opposed to so much being done in the hospitals, as it is today. Subsequent rules and regulations would be drawn up in order to take care of the details of implementing the bill.

After approaching insurance companies for their input, Mr. Blader will report any amended version to the Council within a year.

BOARD OF TRUSTEES REFERRAL— NEW JERSEY COALITION FOR PRIVATE MEDICAL PRACTICE IN URBAN AREAS

The Board of Trustees referred the communication from the New Jersey Coalition for Private Medical Practice in Urban Areas, requesting support, to the Council on Medical Services for study and recommendation.

The Council reviewed the material and appointed an Ad Hoc Committee to study this request. The Ad Hoc Committee, upon investigating the matter, reported back to the Council that it recommended that MSNJ support the Coalition. The members of the Council, upon being polled by mail, recommended and the Board approved the following (note was made of those on the Council who voted negatively and did so because of the support for legislation for physicians' assistants by the Coalition):

That MSNJ lend its support to the efforts of the New Jersey Coalition for Private Medical Practice in Urban Areas by serving on their Advisory Board.

PREADMISSION TESTING OFFICE CONSULTATION (PATOC)

A nine-month progress report of PATOC in regard to the payment of consultation fees for consultations done in the consultant's office prior to admission to the hospital, was reviewed. In the first nine months, ten claims were received, four of which were paid and six declined. Blue Shield spent approximately \$5,400 to start the Program last year.

The Council recommended and the Board approved that the Program be continued for one year.

ELECTIVE SURGERY SECOND OPINION (ESSOP)— STATUS REPORT

This Council continues to receive status reports on this Program. It was agreed that it is still too early to arrive at any valid conclusions. Agreeing with the Council's opinion, the Board authorized the Executive Committee and staff to reply expeditiously to any future comments released by the Department of Insurance, in regard to premature interpretations of statistics gathered to date under this program.

Filed in accordance with the recommendation of the Reference Committee.

Occupational Health, Workmen's Compensation, and Rehabilitation

Elmer J. Elias, M.D., Chairman, Trenton

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

No action necessary.

Medicaid

Harvey J. Shwed, M.D., Chairman, Newark

(Reference Committee "F")

The Medicaid Committee has continued to be active. It has been an exciting, sometimes tempestuous year. A Medicaid Committee-sponsored, House of Delegates Resolution ran into political difficulty. (Negotiations between the Governor's office and the Medical Society concerning issues of physician reimbursement under the Medicaid program are continuing at the time of the submission of this report.)

The Committee chairman appeared before a Joint Senate and Assembly Appropriations Committee meeting to plead for the reinstitution of budget items slated for fee increases which had been deleted by the Department of Human Services and the Governor's office.

Despite Medicaid statistics which underscore the inequity of the reimbursement system, no new budgetary increases were included nor are any expected for the next fiscal year. (Statistics continue to document that hospital emergency rooms and outpatient facilities are reimbursed at a much higher rate than private physicians for similar services. Hospital facilities also receive inflationary increases each year, a practice denied to private physicians in the Medicaid program.)

Meetings continue to be well attended both by members of the Medical Society, county affiliates, specialty societies, and invited guests from other health private practice organizations.

The following is a list of other Committee activities this year:

There was ongoing dialogue with Medicaid concerning appropriate protocol *vis-à-vis* auditing procedures and practices. An important concession that was obtained from Medicaid was that doctors who were the subject of routine audits would receive a "critique" within a nine-month period. Heretofore, doctors never were informed as to the outcome of their audits.

Similar protocol was developed in relation to "informal interviews" between Medicaid officials and individual practitioners when these are requested by Medicaid officials.

This year saw a representative from the Public Advocate's Office attend some of our Medicaid meetings. In its continuing dialogue with Medicaid, the Committee is stressing the constructive and educational potential for the auditing process, i.e., the audit could be an opportunity for Medicaid officials and the private practitioners to discuss standards of practice and for constructive criticism to take effect before penalties or "worse" are leveled against the practitioner.

The so-called IMP number (the identification number for individual practitioners) was altered so that it would not be identical with the individual physician's social security number, as originally had been planned by Medicaid.

A Subcommittee was formed to begin to discuss changes and revisions in Medicaid regulations. This will be a slow and arduous process and ultimately may devolve upon the specialty societies for their further negotiation with Medicaid.

Continuing discussion concerning the geographical site of "fair hearings" was an issue this year as it has been in previous years. The Medicaid Committee feels strongly that doctors are penalized and are discouraged from participating in the "fair hearing" procedure if they have to travel inordinate numbers of miles to Trenton to do so.

Medicaid officials asked the Medical Society if it would convey to its membership the importance of properly filling out prescriptions with appropriate identifying material, addresses, and so on, and signing prescriptions so they can be read.

The Board of Trustees has approved our recommendation that the Medical Society in conjunction with the Division of Medical Assistance and Health Services (Medicaid), sponsor an all-day session on issues relevant to Medicaid, Medicaid patients, and the Medicaid provider.

Filed in accordance with the recommendation of the Reference Committee.

Membership Inquiry and Complaints

Joseph C. Lucci, Director, Medical and Insurance Affairs,
Lawrenceville

(Reference Committee "F")

INQUIRIES AND COMPLAINTS MARCH 7, 1978 TO MARCH 1, 1979

MEDICARE

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of seventeen complaints were received. One complaint is pending.

MEDICAID

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of four complaints were received.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of seven complaints were received. One complaint is pending.

OTHER HEALTH INSURANCE CARRIERS

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of six complaints were received.

Filed in accordance with the recommendation of the Reference Committee.

Mental Health

Harry H. Brunt, M.D., Chairman, Neptune

(Reference Committee "F")

The Council on Mental Health met on September 13, November 8, 1978, and January 10, 1979. Much of the Council's work consisted of reviews of proposed mental health bills in the state legislature. We also reviewed administrative bulletins promulgated by the Department of Human Services that were either infringements on the practice of medicine or attempts to implement policies that possibly were detrimental to patient care and treatment. We have

before us a research project on epilepsy, but have not finalized a recommendation. We hope to have a sub-committee on child psychiatry appointed permanently to deal with the ever-changing scene of the treatment of children and adolescents.

Filed in accordance with the recommendation of the Reference Committee.

Drug and Alcohol Abuse

Edwin A. Turner, Jr., M.D., Chairman, Upper Saddle River

(Reference Committee "F")

The Board of Trustees established the Ad Hoc Committee on Drug Abuse as recommended by the Council on Mental Health. During its deliberations it was recommended and approved by the Board of Trustees that the title be revised to the Ad Hoc Committee on Drug and Alcohol Abuse.

It was agreed that the focus of the Committee should be in the area of education and prevention of drug and alcohol abuse. It also was agreed that the Committee should become involved in legislative matters regarding marihuana and changing the legal age for drinking. Liaison has been established with the State of New Jersey Department of Health,

and in particular with the Division of Alcohol, Narcotic, and Drug Abuse Control.

Mr. Richard J. Russo, reviewed for the Committee, recommendations made by the New Jersey Drug Abuse Advisory Council regarding marihuana legislation. He explained that the Council favors review of the law in two years to determine its effectiveness. The Committee discussed the use of the word "decriminalization" and felt that when the public hears this word it automatically associates it with legalization, causing the defeat of the legislation. It was felt that the word "decriminalization" should not be used at all

in connection with the new push to get this legislation passed. The Committee recommended and the Board approved that the Medical Society of New Jersey support the marihuana resolution dated September 21, 1976 as presented by the New Jersey Drug Abuse Advisory Council.

In conjunction with the Department of Health, articles pertaining to drug and alcohol abuse are being submitted to *The Journal* for publication in the near future.

Filed in accordance with the recommendation of the Reference Committee.

Impaired Physicians

Arthur McLellan, M.D., Chairman, Summit

(Reference Committee "F")

The Impaired Physicians' Committee during the past year had directed its efforts to program and method refinement in preparation for formal implementation on January 1, 1979. Prior to that date, although not formally in operation, there were twelve referrals to the Committee during the year and a variety of dispositions made which included referral for residential treatment, Alcoholics Anonymous, and counseling services. Formal announcement of program availability was made to all licensed physicians in the State of New Jersey on January 1, 1979. Subsequent activity has been substantial

with numerous inquiries from all over the State of New Jersey. There are several cases which currently are under consideration and processing. The Committee has had a great deal of cooperation in its development in working with Medical Society staff and the New Jersey Board of Medical Examiners, both of which have facilitated and enhanced the development of the program.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#20 Insurance Benefits for Psychiatric Care

From the Passaic County Medical Society

(Reference Committee "F")

Whereas, the Medical Society of New Jersey is concerned with the crisis in the delivery of mental health care in the State of New Jersey, resulting from the growing failure of the public sector to provide treatment for appropriate patients, thus shifting the responsibility to psychiatrists in private practice and increasing the existing burden on the private sector; and

Whereas, the AMA House of Delegates (June, 1978) again reaffirmed its policy mandating provision of benefits for emotional and mental illness under all governmental and private insurance programs equivalent in scope and duration to those benefits provided for other medical or physical illnesses; now therefore be it

RESOLVED, that the House of Delegates specifically commits the Medical Society of New Jersey to the policy of the AMA regarding the treatment of emotional and mental illness, and instructs its Board of Trustees and Officers to institute all measures within its power to ensure that the people of New Jersey will receive the quality of medical care envisioned in the policy of the AMA House of Delegates, through the provision of benefits for the care of emotional and mental illness under all government and private insurance programs, equivalent in scope and duration to those benefits provided for other medical or physical illness.

Adopted in accordance with the recommendation of the Reference Committee.

Multiphasic Screening Programs

From the Union County Medical Society

(Reference Committee "F")

Whereas, health fairs, multiphasic screening programs or centers, and industrial health programs gather information for the alleged purpose of improving the health of the public; and

Whereas, such information is often sent to a private physician who has not requested it, thus conveying an apparent responsibility for informing the patient as to abnormal results; and

Whereas, the burden of follow-up is then placed upon the physician to contact a patient who may either be unknown to him or inactive for many years; and

Whereas, a notice to the patient that test results are abnormal with no explanation other than advice to see the physician creates feelings of anxiety and concern on the part of the patient; and

Whereas, the alleged abnormal results often must be repeated or confirmed at a further expense to the patient; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey peti-~~

~~tion appropriate state agencies to require that health fairs and other multiphasic screening programs send test results directly to the patient with an explanation of any abnormal results and instructions to contact his personal physician when appropriate; and that such test results in no case be conveyed directly to the physician named by the patient; and be it further~~

Amended by House to read:

RESOLVED, that the Medical Society of New Jersey petition appropriate state agencies to require that health fairs and other multiphasic screening programs send test results directly to the patient, indicating any abnormal results and with instructions to contact his/her personal physician when appropriate; and that such test results in no case be conveyed directly to the physician named by the patient; and be it further

RESOLVED, that patients be notified by such test centers that it may be proper medical procedure for the attending physician to repeat abnormal tests.

Reference Committee recommendation had been for referral to the Council on Medical Services.

Adopted as amended by the House.

Regulation and Cost Containment

From the Essex County Medical Society

(Reference Committee "F")

Whereas, many national, state and local agencies routinely inspect and regulate hospital physical facilities and activities; and

Whereas, many of their inspections are overlapping in nature and require much hospital staff time to comply with the inspection and regulation; and

Whereas, Medicare, Medicaid, and other third party payors have separate audits, and substantial cost savings could be realized through a common audit; and

Whereas, it is often costly for the hospital to carry out and comply with all their many and varied requirements; and

Whereas, the cost of complying with government regulations has been estimated to be as high as 25% of the daily cost of a hospital stay; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey sup-~~

~~port the New Jersey Hospital Association's endeavors to eliminate costly, unnecessary overlapping of both inspection and regulatory mechanisms as part of our voluntary health cost-containment program; and be it further~~

Amended by Reference Committee by deletion of above "Resolved" and insertion of the following:

RESOLVED, that as part of its voluntary health cost containment program, the Medical Society of New Jersey support the New Jersey Hospital Association's endeavors to eliminate costly, unnecessary overlapping both of inspection and regulatory mechanisms; and be it further

RESOLVED, that the AMA Delegation introduce and speak for a similar resolution at the next meeting of the AMA House of Delegates.

Adopted as amended, for purposes of clarification, by the Reference Committee.

#23

Restriction on the Establishment of Satellite Clinics

From the Union County Medical Society

(Reference Committee "F")

Whereas, free-standing ~~and~~ hospital, satellite outpatient clinics are becoming increasingly numerous throughout New Jersey; and

Whereas, patient care at such clinics is fragmented since no care is provided after hours or on weekends; and

Whereas, the patients of such clinics then become the responsibility of the private practitioner or utilize the expensive resources of emergency rooms; and

Whereas, establishment of satellite clinics in such areas results in expensive and unnecessary duplication of services; without improving the quality of care; now therefore be it

RESOLVED, that the Medical Society of New Jersey demand **that** the New Jersey Department of Health and the New Jersey Department of Human Services ~~to~~ seek the advice and consultation of the local county medical society, which is most acutely aware of local medical needs, before granting permission for the establishment of a free standing, ~~or~~ hospital satellite clinic in a given area.

Referred to the Board of Trustees after inclusion of editorial changes by the Reference Committee.

The Reference Committee had recommended adoption.

#24

Treatment of the Compulsive Gambler

From the Essex County Medical Society

(Reference Committee "F")

Whereas, compulsive gambling is a self-destructive disease; and

Whereas, there is evidence it is amenable to cure and that the physician can serve as a consultant helping the gambler to shape his own rehabilitation program; and

Whereas, it is estimated that a rapid escalation of the incidence of this disease has grown throughout the United States in the past ten years; and

Whereas, the first in-hospital program for the treatment of pathological gamblers began at the Brecksville Division of the Cleveland VA Hospitals; and

Whereas, compulsive gamblers have a psychological uncontrollable preoccupation with gambling which can even destroy the individual's life if a rehabilitation program is not available; and

Whereas, one will get you five that effective rehabilitation

programs can be obtained through legislation and physician counseling; now therefore be it

RESOLVED, that the Medical Society of New Jersey recognize compulsive gambling as a self-destructive disease which is amenable to proper rehabilitation and physician counseling; and be it further

RESOLVED, that the Medical Society of New Jersey join with other concerned groups to develop legislation which would establish appropriate rehabilitative services in the State of New Jersey.

Referred to the Council on Mental Health for investigation and report to the Board of Trustees and the House of Delegates at its next regular meeting.

Reference Committee had recommended rejection on the grounds that the need for rehabilitation of compulsive gamblers had not been demonstrated.

Voluntary Effort

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, increases in the cost of medical care are real and continuing, causing concern by individuals, families, business, government, and physicians; and

Whereas, much of the increase in cost is caused by new technology and treatment methods which result in better care, prolonged life or a better quality of life; and

Whereas, other important factors causing the increases in costs are government regulations, higher labor, energy and malpractice costs, and general inflation; and

Whereas, the American Medical Association, American Hospital Association, and Federation of American Hospitals late in 1977 created the Voluntary Effort aimed at moderating increases in hospital charges, which have already begun to moderate; and

Whereas, Tom E. Nesbitt, M.D., President of the American Medical Association, called on physicians in his inaugural address to use similar restraint in their fee increases; now therefore be it

RESOLVED, that the Medical Society of New Jersey endorse the call by AMA President Tom Nesbitt, M.D., for physicians to help moderate increases in medical care costs by using appropriate restraints to keep fee increases more nearly in line with the annual increase in cost of living; and be it further

~~RESOLVED, that the Medical Society of New Jersey endorse the Voluntary Effort as a responsible private-sector activity to restrain increases in hospital costs without arbitrary limits or government intervention.~~

Amended by the Reference Committee by deletion of the above "Resolved" and substitution of the following:

RESOLVED, that as a responsible private-sector activity to restrain increases in hospital costs without arbitrary limits or government intervention, the Medical Society of New Jersey endorse the Voluntary Effort.

Adopted as amended by the Reference Committee.

South Jersey Medical Education Program Clinical Campus

From the Camden County Medical Society

(Reference Committee "F")

Whereas, the Board of Higher Education has unanimously accepted and approved the report of its Special Committee on Scope and Cost of Health Professions' Education; and

Whereas, this position determines that no basic science facility for either allopathic or osteopathic students be constructed in South Jersey because it is academically and economically unsound; and

Whereas, this Policy determines that only a clinical campus be established for allopathic medical students in Camden and osteopathic medical students in Stratford; and

Whereas, only a small administrative building be constructed for offices of the clinical faculty and classrooms for both allopathic and osteopathic students; and

Whereas, the Board of Trustees of the Medical Society of New Jersey has endorsed this position; and

Whereas, all members of the Medical Society of New Jersey

should be made aware of the matter of South Jersey medical education; now therefore be it

RESOLVED, that this House of Delegates endorses and supports the position of the Board of Higher Education; and be it further

RESOLVED, that the Medical Society of New Jersey have representatives appointed by the President of the College of Medicine and Dentistry of New Jersey, with the approval of the Chancellor of Higher Education, to participate actively in any future review of the South Jersey Medical Program conducted by the State of New Jersey or any of its agencies; and be it further

RESOLVED, that the Board of Trustees make known this endorsement to the members of the Medical Society of New Jersey, the Governor, the members of the legislature, and the Board of Higher Education.

Adopted in accordance with the recommendation of the Reference Committee and after amendment by the House by insertion of an additional "Resolved" as indicated.

REFERENCE COMMITTEE "G"

Frank J. Malta, M.D., Ocean

Chairman

Joseph W. Fleisher, M.D., Hudson

Leonard S. Rosen, M.D., Bergen

Frank A. Wolf, M.D., Warren

Adolph R. Wichman, M.D., Morris

L. Arne Skilbred, M.D., Essex

Alternate Member

Reports:

Board of Trustees' Items

Committee on Chronically Ill

and Aging

Council on Public Health and its

Special Committees on:

Cancer Control

Child Health

Conservation of Hearing and

Speech

Conservation of Vision

Environmental Health

Maternal and Child Care

Committee on Medical Aspects of

School Sports

Resolutions #26, #27, #28, #29

Board of Trustees' Items

SEPARATE FACILITIES FOR NONSMOKERS

(Reference Committee "G")

Substitute Resolution #15 (1978 House of Delegates) called upon the Society to petition the New Jersey Department of Health to recommend that "no smoking" signs be displayed in all public places and that all New Jersey eating places open to the public provide separate sections, and where feasible, separate rooms for smokers and nonsmokers.

The resolution was forwarded to the New Jersey Public Health Council.

Filed in accordance with the recommendation of the Reference Committee.

Reference Committee heard testimony to the effect that in spite of the difficulties in providing separate rooms for smokers and nonsmokers in public places, the Medical Society should continue to try to implement the intent of Substitute Resolution #15 of the 1978 House of Delegates.

SMOKING

(Reference Committee "G")

The Director of the AMA Division of Scientific Activities has responded to the Society's resolution on smoking indicating that this same issue was brought up in two resolutions presented before the AMA House of Delegates in June, 1978. The AMA House of Delegates adopted the following resolution on curbing cigarette smoking:

RESOLVED, that the American Medical Association reaffirm existing policy which urges physicians to continue to act as nonsmoking exemplars to the public; advise patients of the health hazards of smoking; discourage smoking by

means of public pronouncements and educational programs; discourage visual presentations in the public media which depict smoking as the norm in American culture as a means of influencing young people to refrain from acquiring a smoking habit; and be it further

RESOLVED, that the American Medical Association encourage the elimination of cigarette sales and smoking in medical and health care facilities such as hospitals, clinics, medical schools, and nursing schools, among others; and be it further

RESOLVED, that the American Medical Association continue to cooperate and participate with other organizations in the public and private sector in implementing anti-smoking educational efforts; and be it further

RESOLVED, that the federal government be encouraged to continue to provide financial support for research directed to determining the health hazards related to smoking.

The AMA reference committee concurred with the thoughtful expressions relating to the importance of anti-smoking educational programs as part of the health education efforts needed to promote more healthful lifestyles and reduce the overall costs of remedial medical care. The long-standing policies of the American Medical Association and its efforts to assure dissemination of educational materials to discourage smoking by all segments of society merit reaffirmation and extension. The question of earmarking special taxes for specific programs involves more difficult considerations, however, which deserve extensive public comment and debate. The reference committee consequently proposed the above resolution.

Filed in accordance with the recommendation of the Reference Committee.

Chronically Ill and Aging

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "G")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Reference Committee heard complaints to the effect that a report should be made to the House if it contained nothing more than a summary of the activities in this area going on in the State.

Public Health

Peter A. Gross, M.D., Chairman, Hackensack

(Reference Committee "G")

The Council on Public Health has a meeting scheduled on March 27, 1979.

The Council, by mail ballot, recommended and the Board of Trustees approved that the name of the Special Committee on Maternal and Infant Welfare be upgraded to the Committee on Maternal and Child Care.

At the request of the Department of Education, State of

New Jersey, the Council approved that in the case of persons with a positive PPD and an initially negative chest film, no follow-up chest films are required. The term "persons" applies to school employees, pupils, and parents of pupils.

Filed in accordance with the recommendation of the Reference Committee.

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Reference Committee "G")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Reference Committee heard complaints to the effect that a report should be made to the House if it contained nothing more than a summary of the activities in this area going on in the State.

Child Health

Glenn P. Lambert, M.D., Chairman, Flemington

(Reference Committee "G")

The Committee on Child Health was reorganized on January 31, 1979. At its meeting, business involving the representation to the Education Commissioner's Advisory Council for Handicapped Children was discussed. A review regarding the establishment of a committee on medical aspects of school sports was noted as well.

After discussion of a problem regarding the administration of Glucagon® in a school, the committee requested that the Board of Trustees support the Special Committee on Child Health in recommending that a school nurse be authorized to administer Glucagon® in the treatment of hypoglycemia in

general, and so inform the Medical Society member who has requested this action. The Committee also suggested that a review of this matter and the action of the Board of Trustees be brought to the attention of the membership through *The Journal*.

"The International Year of the Child—1979" (IYC-79) was an important topic. The goals of the IYC-79 focus on:

(a) **Accident Prevention**—because accidents are the greatest cause of death and suffering among American children;

(b) **Nutrition**—because good nutrition starting at concep-

tion and continuing through adulthood is basic to a healthy, productive life;

(c) **Immunization**—because children must be protected against supposedly “conquered” diseases still capable of producing epidemics;

(d) **Health Education**—because effective health education for children, adolescents, and their families can contribute to happier, healthier, and more productive lives.

The New Jersey Chapter of the American Academy of Pediatrics is promoting an accident-prevention program under the direction of Seymour Charles, M.D.

We have asked the Board of Trustees to endorse the health

care initiatives during the “International Year of the Child—1979” and give its full support, together with its members, in attaining the goals of the IYC-79. It is also urged that MSNJ, in so endorsing the IYC-79, support the American Academy of Pediatrics “Speak Up for Children” Program, which promotes seatbelt restraints for infants and children, the program of accident prevention of the New Jersey Chapter of the American Academy of Pediatrics, and the 1978 AMA House of Delegates resolutions to promote breast feeding.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., Chairman, Trenton

(Reference Committee “G”)

The Committee has met three times this year. Nine members, who are extremely interested in the problems of otolaryngology, have been discussing and seeking solutions to such questions as:

1. What are proper standards, methods, and equipment for appropriate screening of hearing.

2. How to support and promote Senate Bill 3025 sponsored by Senator Joseph Merlino. The Chairman attended a hearing by the Education Committee of the New Jersey Senate on this matter and will plan further meetings and input for this legislation.

3. The Committee has agreed on actions to be taken in meeting the challenge by a group of audiologists who are anxious to offer medical care as well as audiologic to the hearing handicapped.

RECOMMENDATION

That every school physician urge the enforcement of screening of hearing in their schools.

We hope thus to discover hearing loss early enough to control it and, where necessary, to provide means of special education. As physicians we are aware that physical problems such as deafness inevitably lead to emotional illness as well if measures are not taken to control them early.

Approved by the House.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Vision

Jordan D. Burke, M.D., Chairman, Summit

(Reference Committee “G”)

The 22nd Annual Eye Health Screening Program was held during the week of September 24, 1978. A total of 93 hospital centers participated in the program. The number of patients screened was 8,907, of which 4,108 had a positive test finding. The testing included visual impairment, ophthalmoscopy, external conditions, and tonometry.

Of those screened, 487 had positive tonometry tests. The

New Jersey Commission for the Blind and Visually Impaired will follow up these cases and report back to the Committee.

Since its inception, this program has screened 210,167 patients.

Filed in accordance with the recommendation of the Reference Committee.

Environmental Health

Philip J. G. Quigley, M.D., Chairman, Elizabeth

(Reference Committee "G")

The Committee is engaged in assembling a "blue ribbon" panel of New Jersey physicians to be available for consultation and advice to the New Jersey Department of Environmental Protection.

A liaison has been established between the Chairperson and the Department. One inquiry, concerning saline atmosphere discharge at a planned power station, was received and was answered with the assistance of the New Jersey Medical School faculty in Newark.

The Committee looks forward to continuing to provide assistance to the Department when needed.

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report

The 1978 House of Delegates approved the recommendation of the Committee on Environmental Health that the

Medical Society appoint a blue-ribbon panel of physicians with expertise and interest in the health-related problems of air pollution. This was referred to the Committee for study and report.

An advisory panel has been formed by the Committee to assist the New Jersey Department of Environmental Protection (DEP) in evaluating the public health effects of air pollution control regulations and programs, to assist the Clean Air Council in evaluating the health effects of air pollution, and to be available to give expert medical testimony regarding the health effects of specific pollutants in cases where the DEP may need medical testimony in a chain of evidence to prosecute a polluter. Twelve physicians have agreed to be members of this panel, as listed below:

Seymour Charles, M.D.
Francis Chinard, M.D.
Brian Collins, M.D.
Albert Ehrlich, M.D.
Stanley R. Lane, M.D.
Albert Minzter, M.D.

E. Spencer Paisley, M.D.
Frank L. Rosen, M.D.
Jung-San Shen, M.D.
Owen A. Shteir, M.D.
William I. Weiss, M.D.
Meyer T. Weissman, M.D.

Filed in accordance with the recommendation of the Reference Committee.

Maternal and Child Care

Peter A. Beaugard, M.D., Chairman, Teaneck

(Reference Committee "G")

The Committee on Maternal and Child Care met on June 21, 1978 and February 22, 1979. At its first meeting, the Special Committee on Maternal and Infant Welfare recommended, and the Board approved, that the name be upgraded to the Committee on Maternal and Child Care in order to conform with AMA recommendations.

SUBCOMMITTEE ON MATERNAL MORTALITY

James P. Thompson, M.D., Chairman

The Subcommittee on Maternal Mortality reviewed nineteen maternal deaths for 1977. It was agreed that the Subcommittee not only review cases, but use these reports to educate obstetric departments and colleagues with the view of preventing future deaths.

SUBCOMMITTEE ON TEENAGE PREGNANCY

Howard N. Jacobson, M.D., Chairman

The Subcommittee on Teenage Pregnancy had many deliberations and discussions in regard to the problem of

teenage pregnancy. They suggested and the Committee agreed that a representative group including students, teachers, administrators, the New Jersey Parenting Council, and the Quality of Life Coalition should be convened. This group would develop a realistic plan to help introduce family life curriculum into the local schools.

The Committee approved these goals and recommended that they be implemented by the Subcommittee after further investigation into the proper means of accomplishing this.

The results and final recommendations from this Subcommittee eventually will be presented to the Board of Trustees for their approval.

Filed in accordance with the recommendation of the Reference Committee.

Medical Aspects of School Sports

Marcel J. Schulmann, M.D., Chairman, Mount Holly

(Reference Committee "G")

This committee was set up in the fall of 1978 as a new committee. There have been three meetings.

1. Basic structuring of the functions of this committee has taken place, specifically to contact, unify, and harmonize the work of trainers, coaches, and physicians through their respective societies.

2. At a later time, it is anticipated that this committee would become a center point of reference for guidance, consultation, and troubleshooting activities for all school systems, their coaches, and their trainers.

At our request the Board of Trustees adopted a position supporting the concept of preventive programs providing for the safety of young athletes.

We have observed that the incidence of injuries in school-age athletes is very high, and the Medical Society of New

Jersey recognizes the interest and responsibilities of physicians, coaches, trainers, and other concerned individuals to provide for the safety of these young athletes. The Society strongly supports the concept of preventive programs to limit such injuries, including, but not limited to, meetings between interested groups to exchange and share information, clinical investigation, and educational programs regarding the health and safety of young athletes.

Periodically press releases will be issued calling attention to the existence and activities of the Committee on Medical Aspects of School Sports.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#26 Availability of Smallpox Vaccine From the Essex County Medical Society

(Reference Committee "G")

Whereas, there is a shortage of smallpox vaccine in usual medical supply outlets; and

Whereas, Essex County physicians must send their patients to Newark Airport for smallpox vaccine; and

Whereas, vaccine should be available to local physicians so that vaccination can be done by the patient's family physician; and

Whereas, pharmaceutical manufacturers seem to have discontinued their individual and small packets of smallpox vaccine and you must purchase enough for 25 people; now therefore be it

RESOLVED, that the Medical Society of New Jersey prevail

~~upon the pharmaceutical companies to produce an adequate and efficient smallpox vaccine for the American public.~~

Amended by Reference Committee by deletion of the "Resolved" and substitution of the following two "Resolves:"

RESOLVED, that the Medical Society of New Jersey study the availability and distribution problems which developed as a result of the decrease of smallpox immunization; and be it further

RESOLVED, that the Medical Society of New Jersey prevail upon the pharmaceutical companies and the local health departments for a more feasible method of distribution and availability.

Adopted as amended by Reference Committee.

#27

Better Nutrition in the Schools

From the Essex County Medical Society

(Reference Committee "G")

Whereas, good nutrition habits should start early in the elementary grades; and

Whereas, audio-visual aids could be appropriately developed for such education in grades K through 12; and

Whereas, a comprehensive teaching program could be developed for presentation in all schools; and

Whereas, such courses could be jointly presented through the assistance of teachers, dietitians, and nursing personnel; and

Whereas, this is not impractical since some communities in New Jersey have developed fine programs of their own which are very successful; and

Whereas, many of the schools presently have vending machines on their premises which contain junk foods which are detrimental to health; and

Whereas, physicians, teachers, and parents are justly concerned over the vast consumption of junk food in the schools; now therefore be it

RESOLVED, that the Medical Society of New Jersey petition the New Jersey Commissioner of Education to have educational aids developed for a comprehensive program for all New Jersey schools which would develop good nutrition habits at an early age to combat present junk food consumption in the schools; and be it further

RESOLVED, that fruits, fruit juices, and other healthful foods be substituted for junk foods in school vending machines.

Adopted by the House as written.

Reference Committee recommendation to amend the "Resolved" was not adopted.

#28

Encourage Withdrawal of Crop Supports for Tobacco

From Robert A. Goldstone, M.D., Delegate, Passaic County

(Reference Committee "G")

Whereas, the Surgeon General of the United States has again determined that cigarette smoking represents a major health hazard to the citizens of the United States; and

Whereas, members of the health profession have an obligation to seek legislation favorable to the health of the public, and to oppose activities which are detrimental to health; and

Whereas, the government of the United States continues to lend economic support, by means of federal subsidies to the growers of tobacco leaf; now therefore be it

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to further federal subsidy of the tobacco crop; and be it further

RESOLVED, that notification of this position be forwarded

to the Senators and Representatives from the State of New Jersey, and otherwise publicized and made known; and be it further

RESOLVED, that a similar resolution be submitted for approval by the American Medical Association; and be it further

RESOLVED, that the following statement be approved as policy of the Medical Society of New Jersey:

It is **indefensible** for governmental action to lend financial support to an addictive habit which is destructive to the health, welfare, and property of the American people.

Adopted in accordance with the recommendation of the Reference Committee after editorial change by that Committee.

Prescription Drug Price and Quality Stabilization Act

From the Ocean County Medical Society

(Reference Committee "G")

Whereas, the Prescription Drug Price and Quality Stabilization Act, NJSA 24:6E-1 et seq., was enacted September 29, 1977, in the State of New Jersey; and

Whereas, the goals of the Act are to encourage and permit advertising of prescription prices and to encourage the use of generic medication; and

Whereas, the Act will affect the patient, physician, pharmacist, and drug manufacturer; and

Whereas, patients, doctors, pharmacists, and drug manufacturers utilize physical appearance, imprints on prescribed medication, as an aid in identifying the medication from a specific company; and

Whereas, brand name drug manufacturers and generic name drug manufacturers may not have any uniform method of identifying a drug by physical appearance; and

Whereas, the pharmacist may not keep on the patient's drug file the source of generic substitution; and

Whereas, it is conceivable that a generic or brand name substitution may later be determined not to be bio-equivalent; and

Whereas, in an emergency a prescription container may not be identifiable because of lack of labelling or the absence of drug manufacturer's identifying imprint on the drug; now therefore be it

RESOLVED, that to accomplish the above whereases, the Medical Society of New Jersey, through its legislative channels, amend the Prescription Drug Program Act so that every prescription dispensed under this Act includes the following:

- (a) Labelling of the prescription as to its generic name or brand name, unit dosage, amount dispensed, and expiration date, unless the physician specifies "do not label."
- (b) The pharmacist must record on the patient's drug file the name and source, drug manufacturer's lot and batch number of the drug prescribed.
- (c) The drug manufacturer must identify to the pharmacist the drug as to its source, lot and batch number.
- (d) In the event of a drug recall, the State Drug Utility Review Council shall be notified by the drug manufacturer as to the drug lot and batch number.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "H"

Thomas E. Mattingly, Jr., M.D., Burlington
Chairman
B. Ralph Wayman, Jr., M.D., Mercer
H. Oliver Brown, M.D., Union
Christopher Babigian, M.D., Bergen
Roya A. Morrow, M.D., Hudson
Roert J. Weierman, M.D., Essex
Alternate Member

Reports:

Committee on Annual Meeting
MSNJ Auxiliary Advisory Committee
Nominations for Emeritus Membership

Annual Meeting

Ralph J. Fioretti, M.D., Chairman, Rochelle Park

(Reference Committee "H")

The year of 1978-79 was the year of "change." Arrangements to hold the 213th Annual Meeting in Cherry Hill were cancelled; negotiations were initiated with the Atlantic City Convention Bureau, the Boardwalk Regency, and the Holiday Inn; Doctor Gardam, Chairman of the Committee for several years, resigned; and I was appointed to serve as Chairman in September.

Midway through the year, because of construction work in the Boardwalk Regency and the possibility of construction work in the Holiday Inn, we were forced to change all existing plans and move the entire Annual Meeting (with the exception of a few social functions) to the Atlantic City Convention Hall. Through the splendid cooperation of the Convention Bureau, the two hotels, and the manager of the Convention Hall, arrangements have been worked out to the satisfaction of all concerned.

In compliance with a directive of the Board of Trustees, your Committee has endeavored to streamline the Annual Meeting as follows:

1. The Golden Merit Award Ceremony and Reception were eliminated, and will be held in the new Society headquarters some time in the near future;
2. The Saturday evening dinner, dance, and entertainment will not be held in 1979;
3. The Monday evening Annual Dinner-Dance has been cancelled for this year.
4. The Governor's Conference, usually held on Saturday morning, has been changed to the "National Issues Workshop," and will feature AMA officials as speakers on "Federal Regulations and Medicine."

This year, we again will be able to schedule scientific and informational exhibits. If we had known earlier that we were going to utilize the Convention Hall, we would have been able to present technical exhibits also. The Medical Assistants again will sponsor the Message Center; the Prudential Insurance Company will sponsor the Coffee Lounge; and four insurance companies will present exhibits (Blanksteen, Blue Shield of NJ, Medical Inter-Insurance Exchange, and Donald F. Smith).

Hosts for the inaugural reception and dinner to be held Sunday evening will be the Bergen County Medical Society and MSNJ. An outstanding musical/entertainment program by Danny Davis and his Nashville Brass has been arranged; all members are cordially invited. Tickets will be on sale—\$5 per person for the cocktail reception; \$30 per person for the dinner.

Seventy-one outstanding speakers will participate in 19 scientific sessions to be presented on Sunday and Monday by MSNJ's 25 scientific sections, in conjunction with the NJ specialty societies. The 11th Annual Spencer T. Snedecor Trauma Oration is scheduled for Saturday, and will be sponsored by the NJ Committee on Trauma, American College of Surgeons. Reference Committees will meet on Saturday afternoon and Sunday morning; Roche again will sponsor the Motion Picture Theatre; the Annual Prayer Breakfast is scheduled for Sunday morning; following the JEMPAC Breakfast on Monday, there will be a JEMPAC Political Action Seminar, and the JEMPAC Wine and Cheese Reception will be held that afternoon; the NJ Foundation for Health Care Evaluation will present a program on Monday afternoon; and several NJ specialty societies will hold luncheons in conjunction with the scientific sessions on Sunday and Monday.

We are most pleased that the ballroom of Convention Hall, which has been assigned for the sessions of the House, will be ample to ensure the comfort of the Delegates.

Your Committee is grateful to all who have worked so hard to make the 213th the success that we hope it will be.

Reference Committee noted that there was no charge for the use of Convention Hall, effecting a saving to the Society of about \$7,000. It was pointed out that it would be several years before there would be one hotel large enough to accommodate the entire convention, however, the two hotels used this year would be completed by next Spring. Since the availability of facilities in other cities in New Jersey continues to be a problem, it was the consensus that Atlantic City probably would be the appropriate location, but the details should be left to the Annual Meeting Committee.

Filed in accordance with the recommendation of the Reference Committee.

MSNJ Auxiliary Advisory

Frederick W. Durham, M.D., Chairman, Haddonfield

(Reference Committee "H")

Not a solitary meeting session was necessary again this year. However, close ties were maintained via telephone and written correspondence. The Advisory Committee fully sanctioned all the following Auxiliary activities:

1. High priority given to fund raising both for the Medical Student Loan Fund and AMA-ERF.
2. Continuance of CPR education within the community.
3. Immunization awareness and helping to lessen hospital fears of young children have been successful projects.
4. Various health preventive programs and self-helps have been promulgated successfully.

5. Stress has been given to leadership communications, public relations, both Federal and State legislative activities, and efforts in long-range development.

The Medical Society of New Jersey Auxiliary continues to be a major force in the implementation of facing the "real world" of medicine.

Filed in accordance with the recommendation of the Reference Committee, who suggested that the MSNJ Auxiliary Advisory Committee assist the Auxiliary in increasing its membership.

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1979 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Section 1—Composition (e), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service.

Atlantic County

Anthony G. Merendino, M.D., Margate City; age 74

Bergen County

Frederick G. Dilger, M.D., Hackensack; age 84
Walter Friedland, M.D., Tamarac, FL (formerly Hackensack); age 60
Louis A. Hitzemann, M.D., Maywood; age 79
Herbert E. Reinhold, M.D., Green Pond; age 75
Charles A. Rentrop, Jr., M.D., Singer Island, FL (formerly Wyckoff); age 59
William R. Sillery, M.D., Live Oak, FL (formerly Englewood); age 56
Spencer T. Snedecor, M.D., Memphis, TN (formerly Englewood); age 79
James T. Vanderbeck, M.D., Ridgewood; age 74

Burlington County

John T. Bauer, M.D., San Diego, CA (formerly Mount Holly); age 79
Freeman W. Metzger, M.D., Riverside; age 74
John C. Voss, M.D., Riverton; age 70

Camden County

George P. Keefer, M.D., Wynnewood (formerly Camden); age 64
Jane W. Kienle, M.D., Marlton; age 57
Lawrence F. Kienle, M.D., Marlton; age 56
Daniel Santor, M.D., Berlin; age 69
Daniel H. Stephenson, M.D., Merchantville; age 69

Cumberland County

Ralph S. Phillips, M.D., Bridgeton; age 66

Essex County

Louis Bender, M.D., Salem, CT (formerly Newark); age 66
Pedro A. Cuni, Sr., M.D., Miami Beach, FL (formerly Kearny); age 74
E. Nelson Durchlag, M.D., Palm Beach, FL (formerly Irvington); age 68
Robert E. Farabaugh, M.D., Bricktown; age 69
Frank H. Feldman, M.D., Miami, FL (formerly So. Orange); age 71
Lawrence Gilbert, M.D., Springfield; age 66
Michael J. Hyland, M.D., Whiting; age 66
Herman Kupper, M.D., East Orange; age 68
David B. Meisel, M.D., Lauderhill, FL (formerly Newark); age 70
William D. Melosh, M.D., Upper Montclair; age 55
Samuel H. Pomerantz, M.D., Hallandale, FL (formerly Fort Lee); age 67
Salvadore D. Pentecost, M.D., Hackettstown; age 69
Euston S. Robertson, M.D., Glen Ridge; age 73
Herman I. Roseman, M.D., Southold, NY (formerly Glen Ridge); age 70
Alan L. Smith, M.D., West Orange; age 65
Ralph Tuly, M.D., South Orange; age 65

Hudson County

Vito F. Cangemi, M.D., Jersey City; age 68
William J. McKeever, M.D., North Bergen; age 66

Mercer County

David B. Miller, M.D., Princeton; age 62

Middlesex County

Lydia Adler, M.D., Ft. Lauderdale, FL (formerly New Brunswick); age 65
William A. Balogh, M.D., Watchung; age 69
Sigmund J. Clayman, M.D., Coral Gables, FL (formerly Perth Amboy); age 79
Benjamin Copleman, M.D., Perth Amboy; age 70
Murray Jacobson, M.D., Perth Amboy; age 74
Nathan Karshmer, M.D., New Brunswick; age 76

George J. Kohut, M.D., Perth Amboy; age 69
Philip J. Kunderman, M.D., Neshanic Station; age 67
Sollon M. Lazow, M.D., Matawan; age 74
Michael Mendelson, M.D., Westbury, NY (formerly Highland Park); age 68
Leon Ross, M.D., Princeton; age 75
Ralph E. Siegel, M.D., Mineral City, OH (formerly Perth Amboy); age 64

Morris County

Francis J. Benz, M.D., Chatham; age 69
Max W. Flothow, Jr., M.D., Morristown; age 62
Jaroslav J. Lenko, M.D., Boonton; age 60

Ocean County

Stanley T. Jurewicz, M.D., Point Pleasant; age 62
Graham C. Newbury, M.D., Lavallette; age 70

Passaic County

Daniel Bergsma, M.D., North Haledon; age 70
Louis J. Bohl, M.D., Paterson; age 89
Sidney Gelman, M.D., Hallandale, FL (formerly Paterson); age 73
Louis A. Giglio, M.D., Princeton Jct.; age 67
Albert G. Markel, M.D., Wayne; age 77
James P. Morrill, M.D., Southbury, CT (formerly Paterson); age 69
Vincenzo Onorato, M.D., Pompton Lakes; age 69
Abraham J. Reinhorn, M.D., Fair Lawn; age 75

Salem County

George A. Nitshe, Jr., M.D., Monroeville; age 65

Somerset County

Robert V. Anderson, M.D., Branchburg; age 54
Homer E. Cook, M.D., Bridgewater; age 62

Union County

Ernest C. Lowenstein, M.D., Rahway; age 70
Richard Wagner, M.D., New Providence; age 69

Warren County

Steven J. Stanowicz, M.D., Hackettstown; age 63

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #1

The following additional nominations for election to emeritus membership have been received:

Essex County

Adam Jakiemiw, M.D., Harrison; Age 68
William Taffet, M.D., Belleville; Age 68

Union County

Robert L. Lewis, M.D., Elizabeth; Age 66
William H. Lewis, M.D., New Providence; Age 67

Note: The name of John L. Olpp, M.D., Bergen County, has been withdrawn from the list of nominees for election to emeritus membership.

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #2

The following additional nominations for election to emeritus membership have been received:

Camden County

Arthur J. Casselman, M.D., Haddonfield; Age 91

Passaic County

Michael L. Keller, M.D., Franklin Lakes; Age 71
M. Edward Tell, M.D., Passaic; Age 70
Ralph C. Yeaw, M.D., Paterson; Age 70

Middlesex

Collin E. Lewis, M.D., New Brunswick, Age 73

Approved in accordance with the recommendation of the Reference Committee.

Concern was expressed that the growing number of emeritus members in proportion to the total membership may have an effect on the dues' structure.

Report of the Nominating Committee and Election

Frank R. Begen, M.D., Chairman

Office	Term	Nominee and Committee
President-Elect	1 year	^a Augustus L. Baker, Jr., M.D., Morris
1st Vice-President	1 year	Armando F. Goracci, M.D., Gloucester
2nd Vice-President	1 year	Howard D. Slobodien, M.D., Middlesex
Trustees		
1st District	3 years	Myles C. Morrison, Jr., M.D., Morris
3rd District	2 years	^b Palma E. Formica, M.D., Middlesex
4th District	3 years	Meyer L. Abrams, M.D., Burlington
4th District	3 years	Anthony P. DeSpirito, M.D., Monmouth
5th District	3 years	John A. Surmone, M.D., Salem
Judicial Councilor:		
3rd District	3 years	Albert F. Moriconi, M.D., Mercer
5th District	1 year	^c Ronald M. Fisher, M.D., Cumberland
AMA Delegates:		
	2 years	William J. D'Elia, M.D., Monmouth
	2 years	James S. Todd, M.D., Bergen
AMA Alternate Delegates:		
	2 years	Howard D. Slobodien, M.D., Middlesex
	2 years	^d Edward A. Schauer, M.D., Monmouth
	2 years	Frank Y. Watson, M.D., Essex
	2 years	James H. Spillane, M.D., Warren
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut:		
Delegate	1 year	Edward M. Coe, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
3rd District	3 years	Leon A. Fraser, M.D., Mercer
4th District	1 year	^e Irving Ratner, M.D., Burlington
Medical Services:		
2nd District	3 years	John R. Doyle, M.D., Bergen
3rd District	3 years	William E. Ryan, M.D., Mercer
Mental Health:		
2nd District	1 year	
4th District	3 years	George L. Triebenbacher, M.D., Ocean
5th District	3 years	Alan Kulick, M.D., Cumberland
Public Health:		
2nd District	3 years	Albert Ehrlich, M.D., Hudson
3rd District	3 years	Thomas E. Desmond, M.D., Middlesex
Public Relations:		
3rd District	3 years	Milton R. Bronstein, M.D., Middlesex
6th Member	3 years	Edwin W. Messey, M.D., Burlington
Standing Committees:		
Annual Meeting	3 years	Joseph P. Cillo, M.D., Union
Auxiliary Advisory	3 years	Frank R. Romano, M.D., Union
Finance and Budget	3 years	Palma E. Formica, M.D., Middlesex
Medical Defense		
and Insurance	3 years	Michael J. Doyle, M.D., Monmouth
Medical Education	3 years	William Pomerantz, M.D., Morris
Publication	3 years	Paul J. Hirsch, M.D., Somerset

^aNominated from the floor to replace Dr. Benz who resigned.

^bNominated from the floor to replace Dr. Slobodien who was elected 2nd Vice-President.

^cNominated from the floor to replace Dr. Surmonte who was elected Trustee.

^dNominated from the floor.

^eNominated from the floor to replace Dr. Abrams who resigned.

^fVacancy to be filled by the Board of Trustees. Dr. Fioretti resigned.

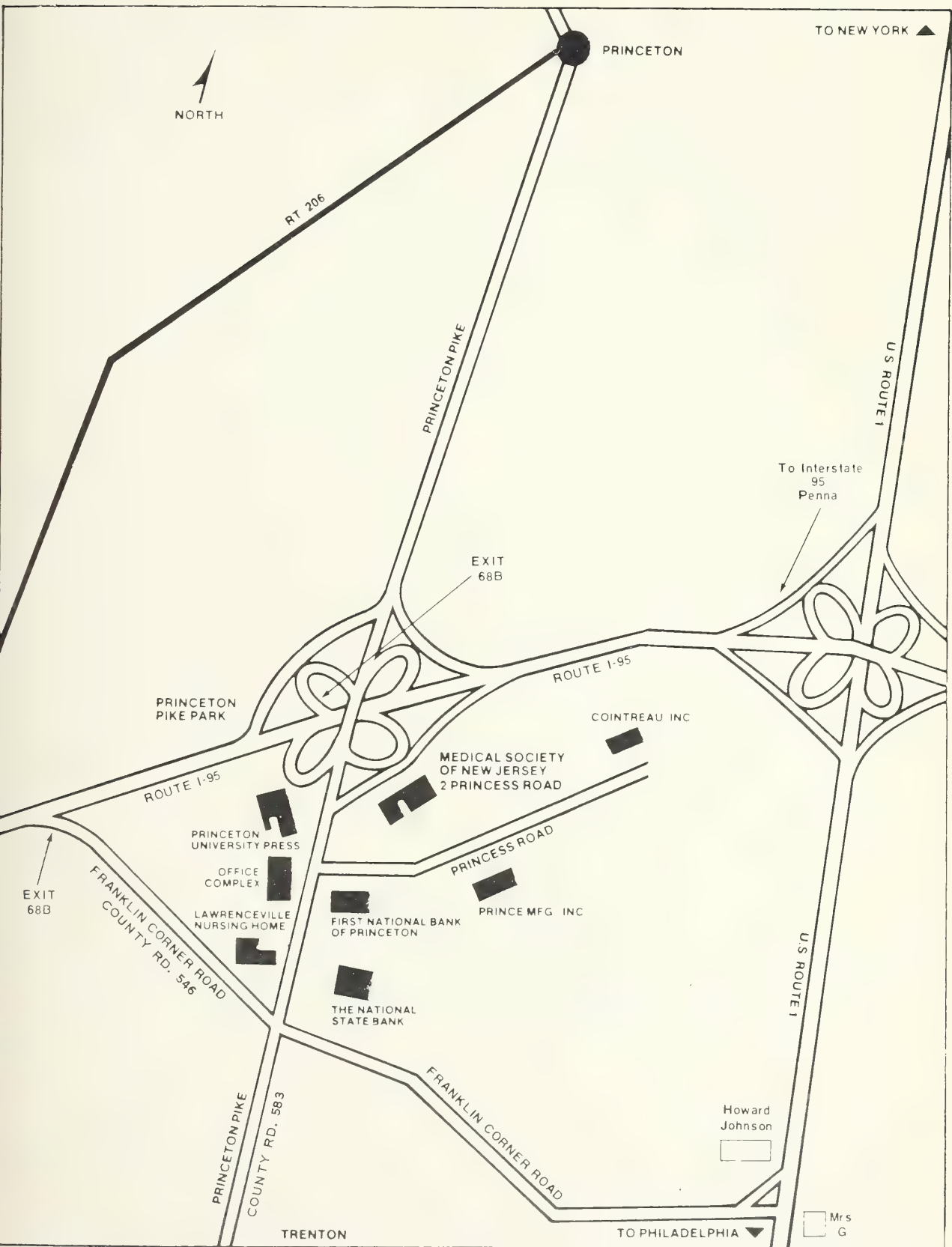
ATTENDANCE

County	Delegates	Members	Total
Atlantic	9	44	53
Bergen	38	30	68
Burlington	11	14	25
Camden	24	25	49
Cape May	3	4	7
Cumberland	6	10	16
Essex	65	63	128
Gloucester	5	9	14
Hudson	22	15	37
Hunterdon	2	—	2
Mercer	26	25	51
Middlesex	24	18	42
Monmouth	20	21	41
Morris	21	11	32
Ocean	11	10	21
Passaic	24	21	45
Salem	3	5	8
Somerset	5	4	9
Sussex	3	5	8
Union	30	23	53
Warren	3	2	5
Fellows and Officers	22	—	22
	377	359	736
Physician Guests			81
Physician Exhibitors			21
TOTAL PHYSICIAN REGISTRATION			838
Auxiliary			265
Visitors			385
Exhibitors			78
TOTAL REGISTRATION			1,566

Five-Year Comparative Registration Figures

Year	Physicians	Others	Total
1979	838	728	1,566
1978	962	678	1,640
1977	1,115	1,125	2,240
1976	1,147	801	1,948
1975	1,363	1,079	2,442

Area Map—MSNJ Headquarters



**Transactions
1979 House of Delegates
213th Annual Meeting
The Medical Society of New Jersey**

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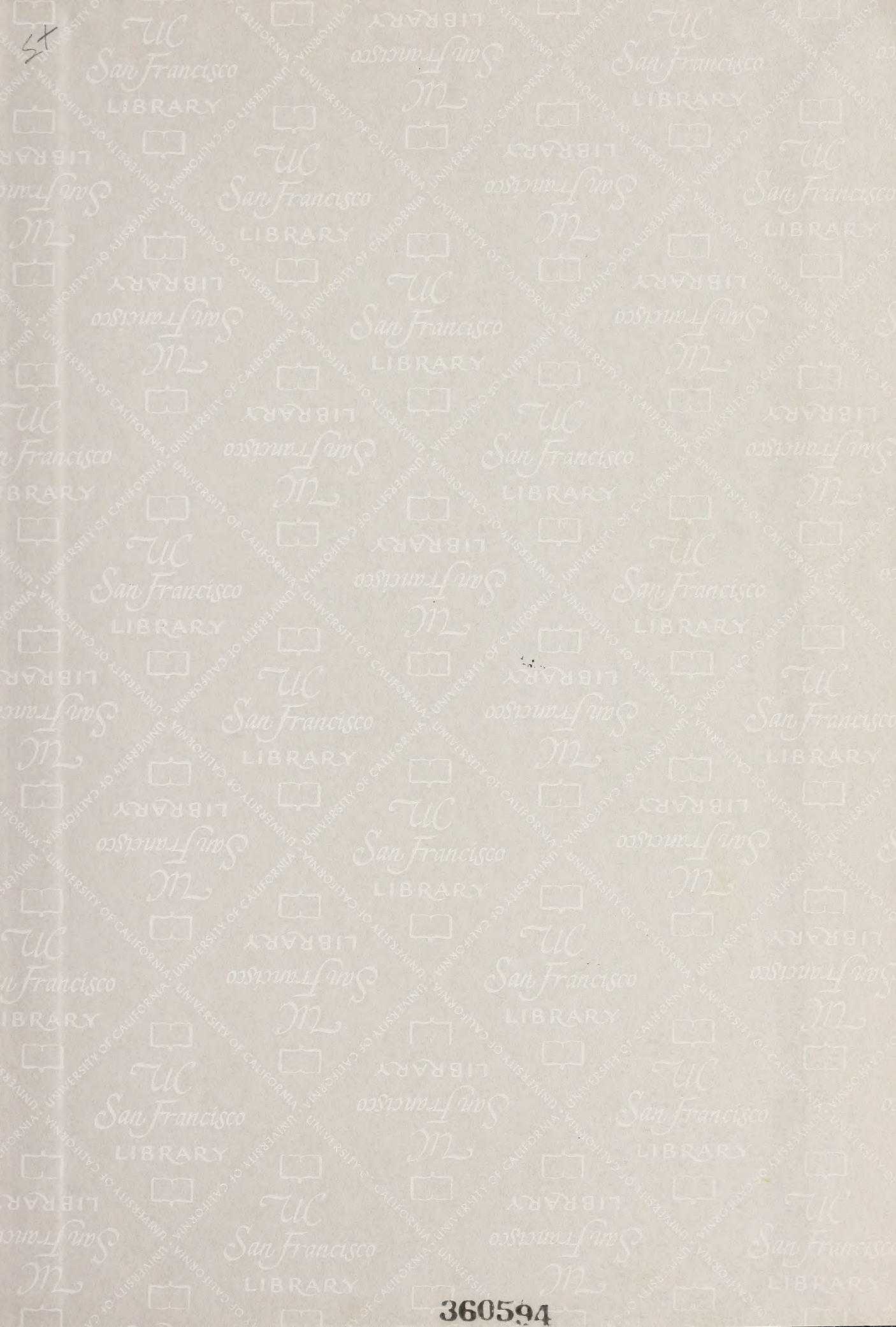
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